

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if necessary, please execute the certificate, writing the word "pending" in pencil. Item 18 Give Pages 1 and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

Item 5 Film No. 12/16/68 MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16292

**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

1. DECEASED NAME (Type or Print)		First <b>Robert</b>	Middle <b>E</b>	Last <b>Able</b>	2a. DATE KNOWN OF ESTI- DEATH MATED <input checked="" type="checkbox"/>	Month <b>11</b>	Day <b>14</b>	Year <b>68</b>	2b. HOUR <b>5:07pm</b>	
3. SEX <b>Male</b>	4. RACE <b>White</b>	S. DATE OF BIRTH <b>9-16-1962</b>	6. AGE (In years last birthday) <b>6</b> YRS.	IF UNDER 1 YEAR MONTHS <b>6</b>	IF UNDER 24 HRS. DAYS <b>14</b>	HOURS <b>11</b>	MIN. <b>14</b>		2d. HOUR <b>5:35pm</b>	
7a. BIRTHPLACE (State or foreign country) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U S A</b>		8. MARRIED <input type="checkbox"/>	NEVER MARRIED <input checked="" type="checkbox"/>	WIDOWED <input type="checkbox"/>	DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH <b>Prince George's Md.</b>		
10. CITY OR TOWN OF DEATH <b>Cheverly</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Prince George Hospital</b>				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Student</b>			12b. KIND OF BUSINESS OR INDUSTRY
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) <b>Maryland</b>			13c. CITY OR TOWN <b>Prince George's Forestville</b>		13d. INSIDE CITY LIMITS? <b>YES</b>		13e. STREET AND NUMBER <b>3521 Ashville Road</b>			
14. FATHER'S NAME <b>Kenneth</b>			First <b>W. Ruehl</b>	Middle <b></b>	Last <b></b>	15. MOTHER'S MAIDEN NAME <b>Ida</b>			Middle <b></b>	Last <b>Fugitt</b>
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16b. SOCIAL SECURITY NO. (If yes give war or dates of service) <b>---</b>		17. INFORMANT <b>Kenneth W. Ruehl</b>			ADDRESS <b>Forestville, Md.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hemorrhagic shock</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause last. <b>814.7</b> (b) _____ DUE TO, OR AS A CONSEQUENCE OF <b>Laceration of liver and right kidney</b> (c) _____ DUE TO, OR AS A CONSEQUENCE OF  PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>8124</b>										
19a. DATE OF OPERATION <b>8/12/4</b>			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? <b>YES</b> <input checked="" type="checkbox"/> <b>NO</b> <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH <b>5:05pm 11-14-1968</b>		21b. TIME OF INJURY Month, Day, Year HOUR A.M. <b>5:05pm 11-14-1968</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) <b>Pedestrian struck by car</b>						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE <b>Ritchie Road</b>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) <b>95 ft. North of Ritchie Spur Rd. Prince George Co., Md.</b>		21f. LOCATION Street or R.F.D. No. City or Town <b>Ritchie Road 95 ft. North of Ritchie Spur Rd. Prince George Co., Md.</b>			County State			
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>										
ACTUAL SIGNATURE <i>John Kehoe</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>			M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		22b. DATE SIGNED <b>11-15-68</b>			
EXAMINER'S NAME (Type) <b>John Kehoe MD</b>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			ADDRESS (Street, city, town, or county) <b>Riverdale, Md.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>11-18-68</b>		23c. NAME OF CEMETERY OR CREMATORIAL <b>Cedar Hill Cemetery</b>		23d. LOCATION (City or Town) <b>Suitland</b> (County) <b>Pr. Geo.</b> (State) <b>Md.</b>				
24. FUNERAL DIRECTOR <b>Wilhelm Funeral Home</b>		ADDRESS <b>4308 Suitland Rd. S. E. Suitland, Md.</b>		25a. RECD BY REGISTRAR <b>NOV 21 1968</b>		25b. REGISTRAR'S SIGNATURE <i>James J. Hogan</i>				

185381

**FOR STATE  
HEALTH DEPT.**

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2 and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office alone, with form F-7M3, Page 5 may be retained for your files.

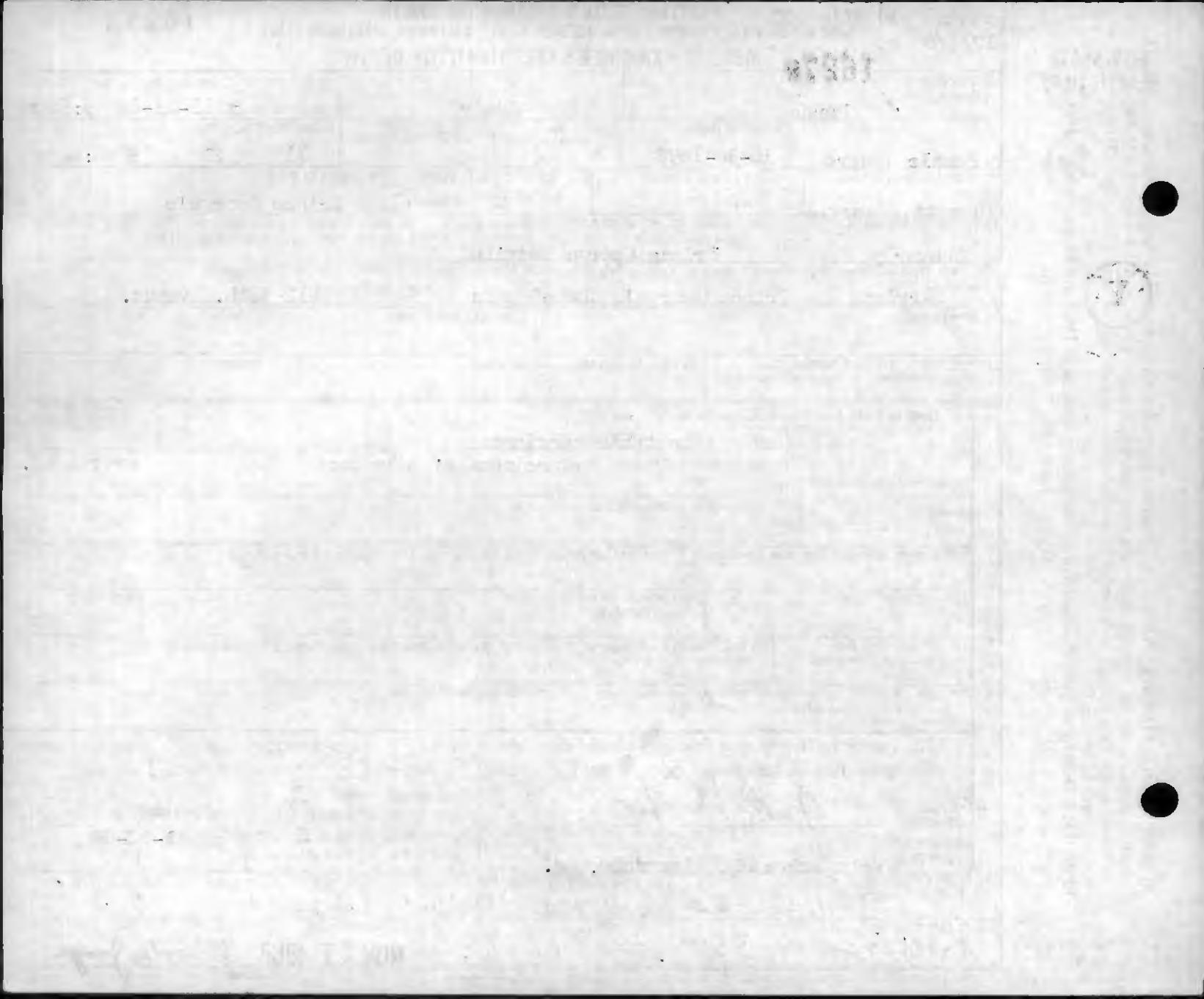
**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

Items 7 & 8 Film GLO7  
12/3/68 kk MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16293

**16279 MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

1. DECEASED NAME (Type or Print)		Middle	Lost	20. DATE KNOWN OF ESTI- DEATH MATED <input checked="" type="checkbox"/>	Month	Day	Year	20b. HOUR
Maude		Adair		11-21-68	19	5:	50pm	
3. SEX	4. RACE	S. DATE OF BIRTH	6. AGE (in years last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS			
Female	Negro	10-30-1898	70 yrs.	MONTHS	DAYS	HOURS	MIN.	
70. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH		2c. DATE PRONOUNCED DEAD Month Day Year		
Parrott Georgia		USA			21 68 1968			2d. HOUR 4:44 pm m
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY	
Cheverly		Prince George Hospital						
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER		
Maryland		Prince George's Chapel Oaks		YES <input type="checkbox"/>	NO <input type="checkbox"/>	1412 58th Avenue.		
14. FATHER'S NAME		First	Middle	Lost	15. MOTHER'S MAIDEN NAME	First	Middle	Lost
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO. (If yes give war or dates of service)		17. INFORMANT		ADDRESS		
1569								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH						
IMMEDIATE CAUSE (a) Metastatic carcinoma		over 6 mo.						
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.								
(b)		DUE TO, OR AS A CONSEQUENCE OF Carcinoma of bile duct						
(c)								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)								
1551		19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
MEDICAL CERTIFICATION								
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M.		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No.		City or Town	County	State
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>								
ACTUAL SIGNATURE		CHIEF MEDICAL EXAMINER <input type="checkbox"/>						
EXAMINER'S NAME (Type)		M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ADDRESS (Street, city, town, or county)						
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE	23c. NAME OF CEMETERY OR CREMATORIAL		23d. LOCATION (City or Town)	(County)	(State)	
11-26-68		Carnes Dr em		Laurel		md		
24. FUNERAL DIRECTOR		ADDRESS		25a. RECD BY REGISTRAR	25b. REGISTRAR'S SIGNATURE			
Bellino 4339-Hunt Pk nE				NOV 27 1968	j Charles Judge			
VR A15ME (5) 10M REV. 1/68		20019						



MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

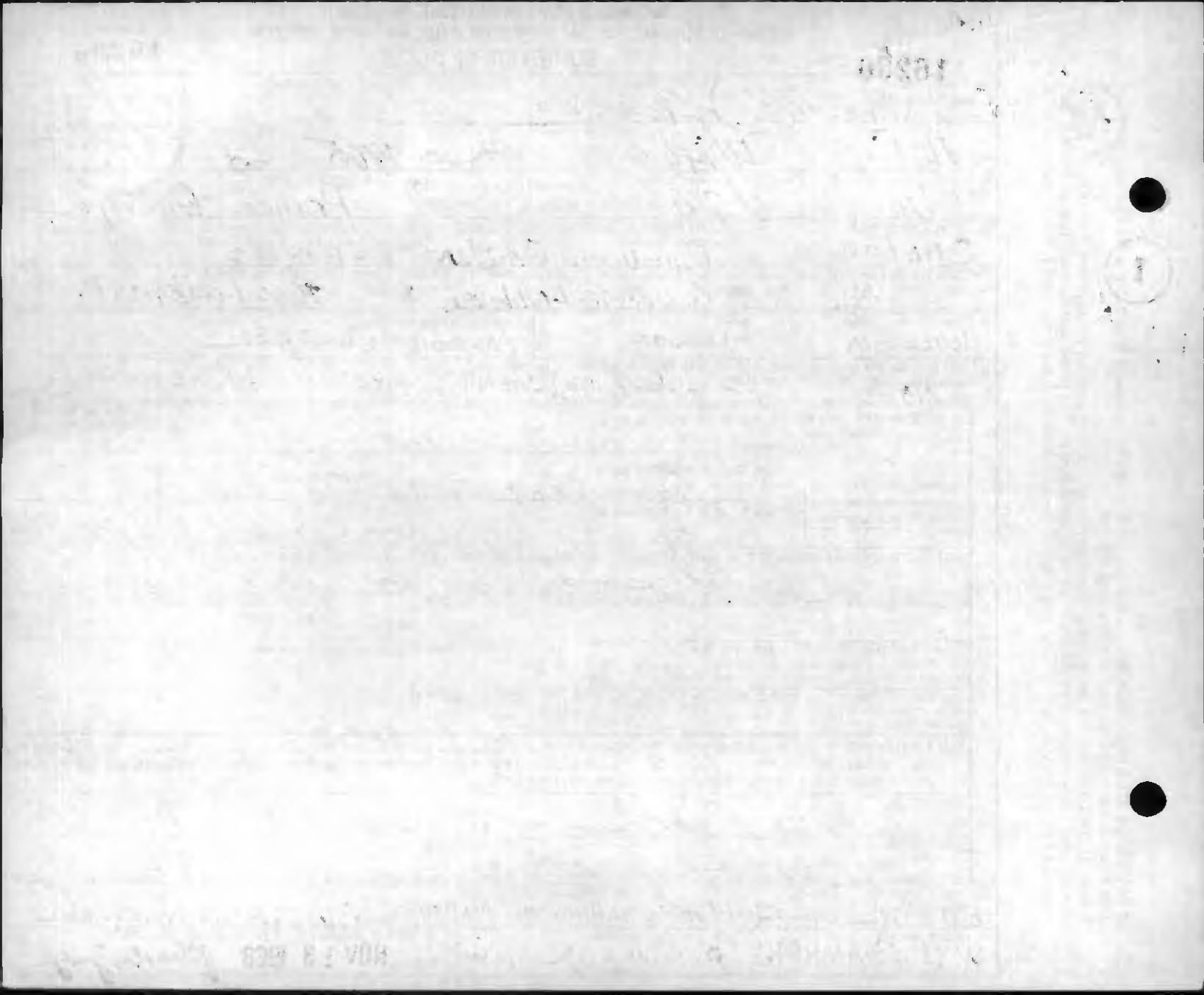
CERTIFICATE OF DEATH

16294

16280				16294			
1. DECEASED NAME (Type or print)		First	Middle	Lost	2d. DATE OF DEATH		2b. HOUR
<i>R. BURTON</i> or ROBERT D. ALLISON					Month	Day	Year
3. SEX		4. RACE	5. DATE OF BIRTH		6. AGE (In years last birthday)		2b. HOUR
<i>M</i>		<i>White</i>	<i>4-10-1905</i>		63		3:15 A.M.
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED		9. COUNTY OF DEATH		
<i>De.</i>		<i>U.S.A.</i>			<i>Prince George</i>		Md.
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY
<i>Clinton</i>		<i>Pineview Garden</i>			<i>LABORER</i>		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY	13c. CITY OR TOWN		13d. INSIDE-CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	13e. STREET AND NUMBER	
<i>N.J.</i>		<i>Pr. George Lanham</i>				<i>7600 Lombard St.</i>	
14. FATHER'S NAME		First	Middle	Lost	15. MOTHER'S MAIDEN NAME		Last
<i>WILLIAM</i>			<i>ALLISON</i>		<i>MADDIE CAMPBELL</i>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown)		16b. SOCIAL SECURITY NO. (If yes give war or dates of service)		17. INFORMANT		Address	
<i>No</i>		<i>326-46-9756</i>		<i>JOHN T. CAMPBELL</i>		<i>SAME AS #13</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiac arrest</i>							
4372 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Circulatory collapse</i>							
(c) <i>pulmonary edema + insufficiency</i> 4-5 hrs							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I <i>4330 Emphysema, chronic severe: asthma bronch</i>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? <input type="checkbox"/> YES <input type="checkbox"/> NO	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town	County State
22a. I certify that (I) (this hospital) attended the deceased from <i>10-27-1968</i> , to <i>11-9-1968</i> , that (I) (we) last saw the deceased alive on <i>11-9-1968</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>Alfred R. Lappin, MD</i>		ATTENDING PHYS. <input type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>	22c. DATE SIGNED <i>11-9-68</i>
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS <i>ALFRED R. LAPPIN, MD</i>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>SERIAL</i>		23b. DATE <i>11-12-1968</i>		23c. NAME OF CEMETERY OR CREMATORIAL <i>WASHINGTON NATIONAL</i>		23d. LOCATION (City or Town) (County) (State) <i>SUITLAND, MARYLAND</i>	
24. FUNERAL DIRECTOR <i>W.W. CHAMBERS</i>		ADDRESS <i>G. RIVERDALE, MD</i>		25a. RECD BY REGISTRAR DATE <i>NOV 13 1968</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal and in any event, within 72 hours after death.



FOR STATE  
HEALTH DEPT.

1 TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if any delay is necessary, please execute the certificate, writing the word "pending" in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with farm PM3. Page 5 may be retained for your files.

2 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

16283

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

16295

1. DECEASED-NAME (Type or Print)		First  Mary	Middle  Jane	Lost  Barger	2a. DATE KNOWN OF ESTI- MATED <input checked="" type="checkbox"/>	Month 11	Day 4	Year 1968	2b. HOUR 30pm
3. SEX Female	4. RACE White	5. DATE OF BIRTH 3-12-1912	6. AGE (In years lost birthday) 56 yrs.	IF UNDER 1 YEAR MONTHS 1	IF UNDER 24 HRS. DAYS 4	HOURS MIN. 1	2c. DATE PRONOUNCED DEAD Month 11		
7a. BIRTHPLACE (State or foreign country) Texas		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		9. COUNTY OF DEATH Prince George's		2d. HOUR 68 19 11 57pm	
10. CITY OR TOWN OF DEATH Cheverly		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Prince George Hospital			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife			12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13c. CITY OR TOWN Prince George's District Heights		13d. INSIDE CITY LIMITS YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER 7512 Foster Street			
14. FATHER'S NAME Charles		Middle B. Moore	Last	15. MOTHER'S MAIDEN NAME Minnie		First ?	Middle ?	Last ?	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16b. SOCIAL SECURITY NO. (If yes give year or dates of service)		17. INFORMANT Conan W. B. Barger		ADDRESS Dist. Hgts. Md. 7512 Foster St.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Massive subarachnoid hemorrhage 4309 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF Rupture of Berry aneurysm (c)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 330X									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No.		City or Town	County	State	
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE  EXAMINER'S NAME (Type) John Kehoe MD		CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ADDRESS (Street, city, town, or county) Riverdale, Md.							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 11-9-68	23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS			23d. LOCATION (City or Town) Prescott		(County)	(State) Arkansas
24. FUNERAL DIRECTOR Wilhelm Funeral Home		25a. REC'D BY REGISTRAR S. E.			25b. REGISTRAR'S SIGNATURE Nov 18 1968 f Charles Judge				

62888

83-Q-II

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "Pending" in Item 18. Give Pages 1, 2 and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

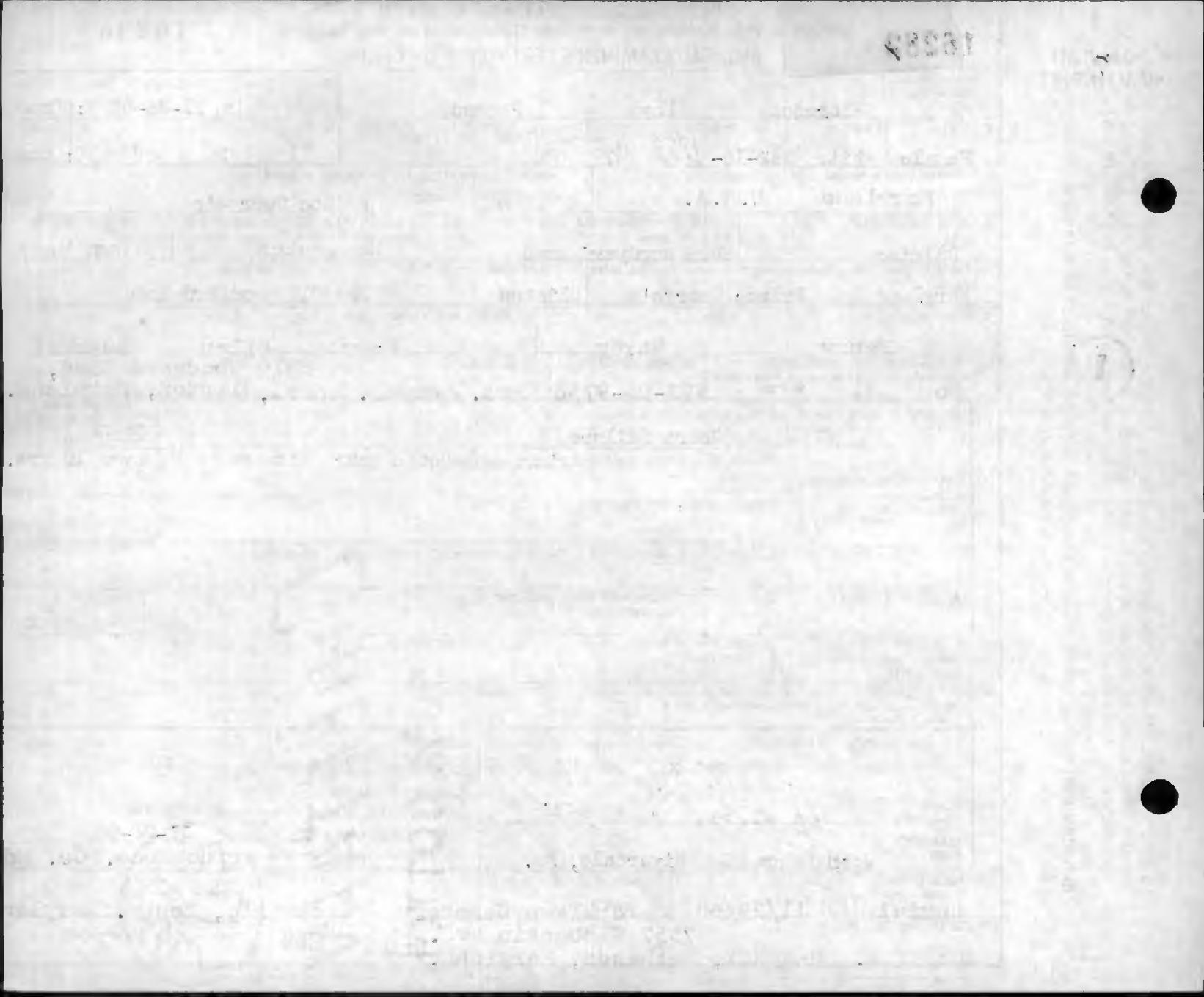
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

16282

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

16296

1. DECEASED NAME (Type or Print)		First	Middle	Last	20. DATE KNOWN OF ESTI- DEATH MATED	Month	Day	Year	2b. HOUR	
		Florence	May	Barnes	<input checked="" type="checkbox"/>	11-26-68	19	00am		
3. SEX	4. RACE	S. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS    DAYS    HOURS    MIN.	2c. DATE PRONOUNCED DEAD				2d. HOUR	
Female	White	12-16-1988	79 YRS.		Month	Day	Year			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH					
Maryland		U.S.A.			Prince George's				Md.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY		
Clinton		8819 Woodyard Road			Homemaker			Own Home		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER				
Maryland		Prince George's		Clinton		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			8819 Woodyard Road	
14. FATHER'S NAME		First	Middle	Last	15. MOTHER'S MAIDEN NAME		First	Middle	Last	
		Henry		Hardy	Mary		Ellen		Boswell	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO. (If yes give war or dates of service)		17. INFORMANT		ADDRESS				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
No		***		577-05-9736		Mrs. Mary B. Adams, Clinton, Maryland.				minutes
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart failure DUE TO, OR AS A CONSEQUENCE OF Arteriosclerotic heart disease										over 10 yrs.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b), DUE TO, OR AS A CONSEQUENCE OF										
(c)										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY?					
					YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M.		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No.		City or Town	County	State		
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>										
ACTUAL SIGNATURE		<i>John Kehoe</i>			CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		22b. DATE SIGNED	
EXAMINER'S NAME (Type)		John Kehoe MD Riverdale, Md.			M.D.		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		11-26-68	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS		23d. LOCATION (City or Town) (County) (State)		ADDRESS (Street, city, town, or county)		
Burial		11/29/68		Parklawn Cemetery 7557 Wisconsin Ave.		Rockville, Montg. Maryland		Prince Geo. Co. Md.		
24. FUNERAL DIRECTOR						25a. REC'D BY REGISTRAR DEC 4 1968		25b. REGISTRAR'S SIGNATURE <i>Robert A. Pumphrey</i>		
ROBERT A. PUMPHREY, Bethesda, Maryland										



MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

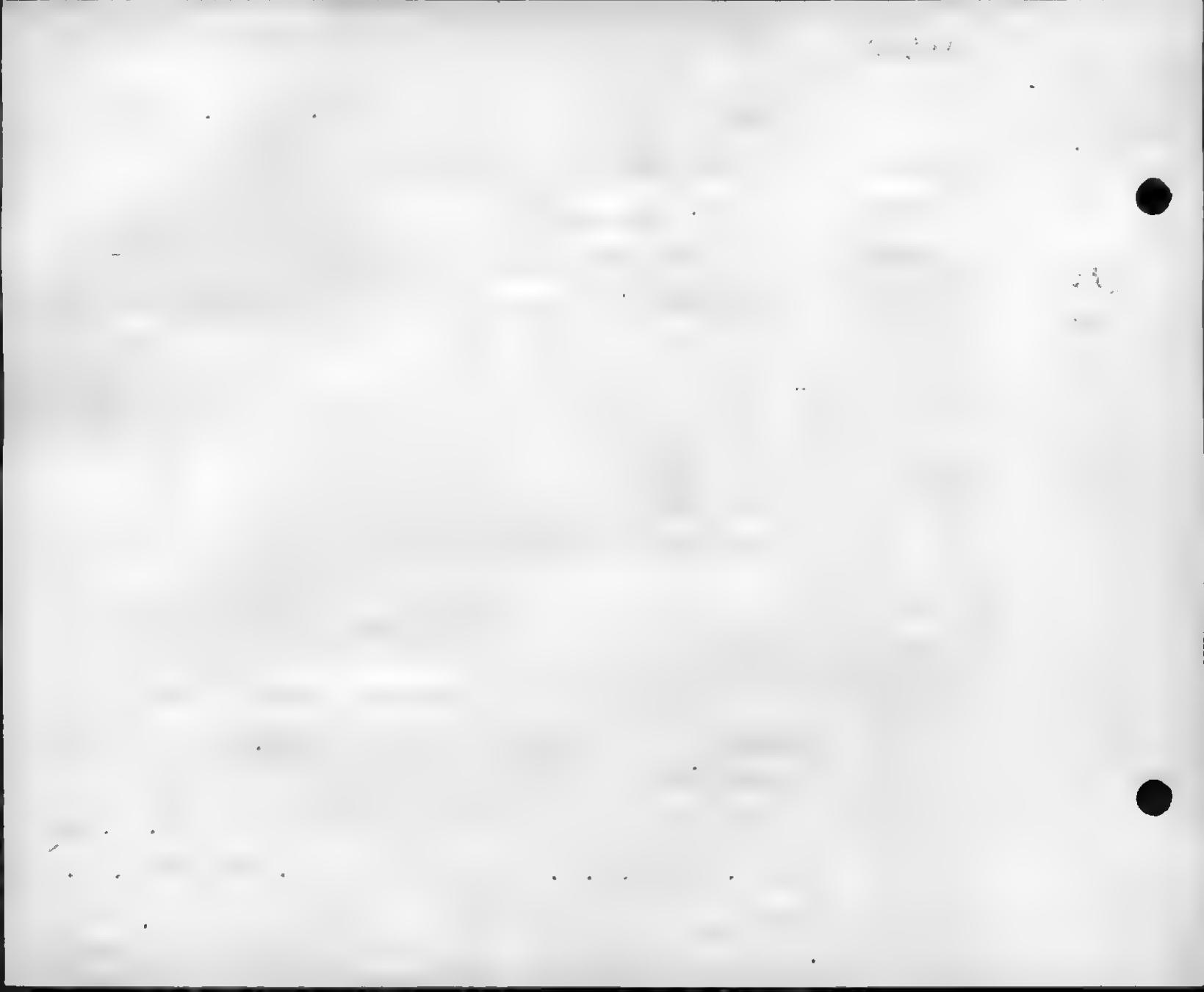
1629

16283

CERTIFICATE OF DEATH

**10 HOSPITAL OR ATTENDING PHYSICIAN:** This law requires that the death certificate be executed within 24 hours after death.  
**10 FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print)		First  Kathryn	Middle  Barrett	Last  Barrett	2a. DATE OF DEATH Month Nov.	Day 22,	Year 1968	2b. HOUR 7:45AM	
3. SEX  Female	4. RACE  Caucasian	5. DATE OF BIRTH 2/27/21			6. AGE (in years last birthday) 47	IF UNDER 1 YEAR MONTHS YRS	IF UNDER 24 HRS HOURS MIN		
7a. BIRTHPLACE (State or foreign country)  Penns.	7b. CITIZEN OF WHAT COUNTRY?  U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH  Prince George's	Md.			
10. CITY OR TOWN OF DEATH  Cheverly	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)  Prince George's	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife			12b. KIND OF BUSINESS OR INDUSTRY				
13a. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) STATE Maryland	13c. CITY OR TOWN Prince George's Landover Hills	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET AND NUMBER 7418 Tilden Street				
14. FATHER'S NAME First Frank Stillson	Middle 	Last 	15. MOTHER'S MAIDEN NAME First Mary ?	Middle 	Last 				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No	16b. SOCIAL SECURITY NO. (If yes give war or dates of service) 204-01-9813	17. INFORMANT David D. Barrett - above address	Address (husband) 2 days						
<p>18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))          PART I DEATH WAS CAUSED BY.          IMMEDIATE CAUSE (a) <u>Cex haesulin</u>          DUE TO, OR AS A CONSEQUENCE OF          Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause          (b) <u>Generalized Carcinomatosis</u>          DUE TO, OR AS A CONSEQUENCE OF          (c) <u>Carcinoma of cervix 1 year</u></p>									
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 171x									
<p>PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)</p>									
MEDICAL CERTIFICATION		19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
		<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH <small>If either, notify medical examiner)</small>			21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State			
<p>22a. I certify that (I) <u>phys hospital</u> attended the deceased from _____, 19_____, to <u>Nov. 22, 1968</u>, that (I) <u>phys</u> lost saw the deceased alive on <u>Nov. 22, 1968</u>, and that in (my) <u>phys</u> opinion death occurred on the date and hour and from the causes stated above, (II) <u>phys</u> (did) <u>phys</u> view the body after death.</p>									
22b. SIGNATURE <u>Dayton O. Watkins</u>		DEGREE ATTENDING PHYS	<input checked="" type="checkbox"/>	MED. DIRECTOR	<input type="checkbox"/>	STAFF PHYS	<input type="checkbox"/>	22c. DATE SIGNED <u>Nov. 22, 1968</u>	
22d. PHYSICIAN'S NAME (Type)  <u>Dayton O. Watkins, M.D.</u>		22e. ADDRESS  <u>5318 Annapolis Rd., Bladensburg, Md.</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 11/25/68	23c. NAME OF CEMETERY OR CREMATORIAL St. Joseph's Cem.	23d. LOCATION (City or Town) Kittanning, Pa.			(County) (State)		
24. FUNERAL DIRECTOR Nalle8's Funeral Home Inc.		ADDRESS Mt Rainier Maryland	25a. REC'D BY REGISTRAR NU. 23 1968	25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			DATE		



MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

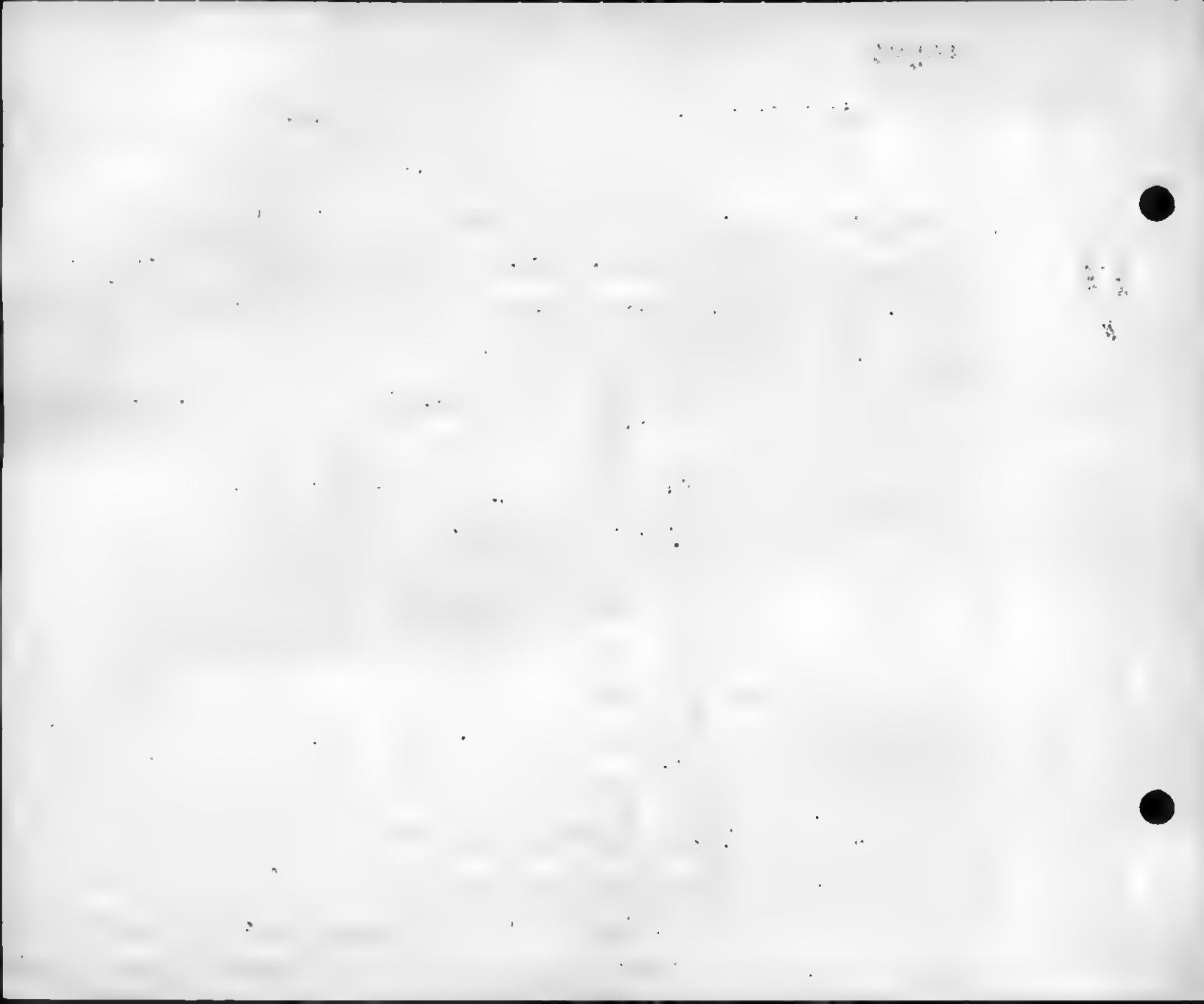
16286

CERTIFICATE OF DEATH

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.  
**Page 4** may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

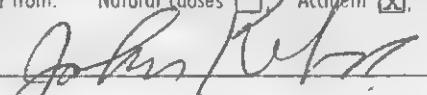
1 DECEASED NAME (Type or print)				First	Middle	Last	2a. DATE OF DEATH Month Day Year	2b. HOUR M
Annie Roberta Beall							Nov. 19, 1968	
3 SEX Female	4 RACE White	5. DATE OF BIRTH Mar. 17, 1909			6 AGE (in years last birthday) 59 YRS.	F JUNIOR 1 YEAR MONTHS DAYS HOURS M.M.	IF UNDER 24 HRS. MONTHS DAYS HOURS M.M.	
7a. BIRTHPLACE (State or foreign country) Savage Md.	7b. CITIZEN OF WHAT COUNTRY? U.S.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH Prince George			
10. CITY OR TOWN OF DEATH Riverdale	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Elmwood Mem. Hospst.			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Housewife Cafeteria worker			12b. KIND OF BUSINESS OR INDUSTRY school	
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE Md.	13b. COUNTY Prince George	13c. CITY OR TOWN Laurel	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER 205 10th St.				
14. FATHER'S NAME Albert Smith	First	Middle	Last	15. MOTHER'S MAIDEN NAME Eliza	First	Middle	Last	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown no	16b. SOCIAL SECURITY NO.			17. INFORMANT Helen Barnard	Address Charles Town Va.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 2509 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (b) <i>Altered Senses - Anoxia</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Diabetes Mellitus</i>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) ( ) X								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No	City or Town	County	State	
22a. I certify that (I) (this hospital) attended the deceased from <i>Nov. 19, 1968</i> , to <i>Nov. 19, 1968</i> , that (I) (we) last saw the deceased alive on <i>Nov. 19, 1968</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								22c. DATE SIGNED <i>Nov. 19, 1968</i>
22b. SIGNATURE <i>Albert Smith, M.D.</i>								22d. MEDICAL CERTIFICATION DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22e. ADDRESS <i>Second Ward</i>
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Cremation</i>		23b. DATE <i>11-21-68</i>	23c. NAME OF CEMETERY OR CREMATORIAL <i>Ft Lincoln Cem</i>			23d. LOCATION (City or Town) (County) <i>Calverton Manor Md.</i>	(State)	
24. FUNERAL DIRECTOR <i>Anthony J. H.</i>		ADDRESS <i>Juravil Md.</i>			25a. REC'D BY REGISTRAR <i>DA 11-25-1968</i>	25b. REGISTRAR'S SIGNATURE		

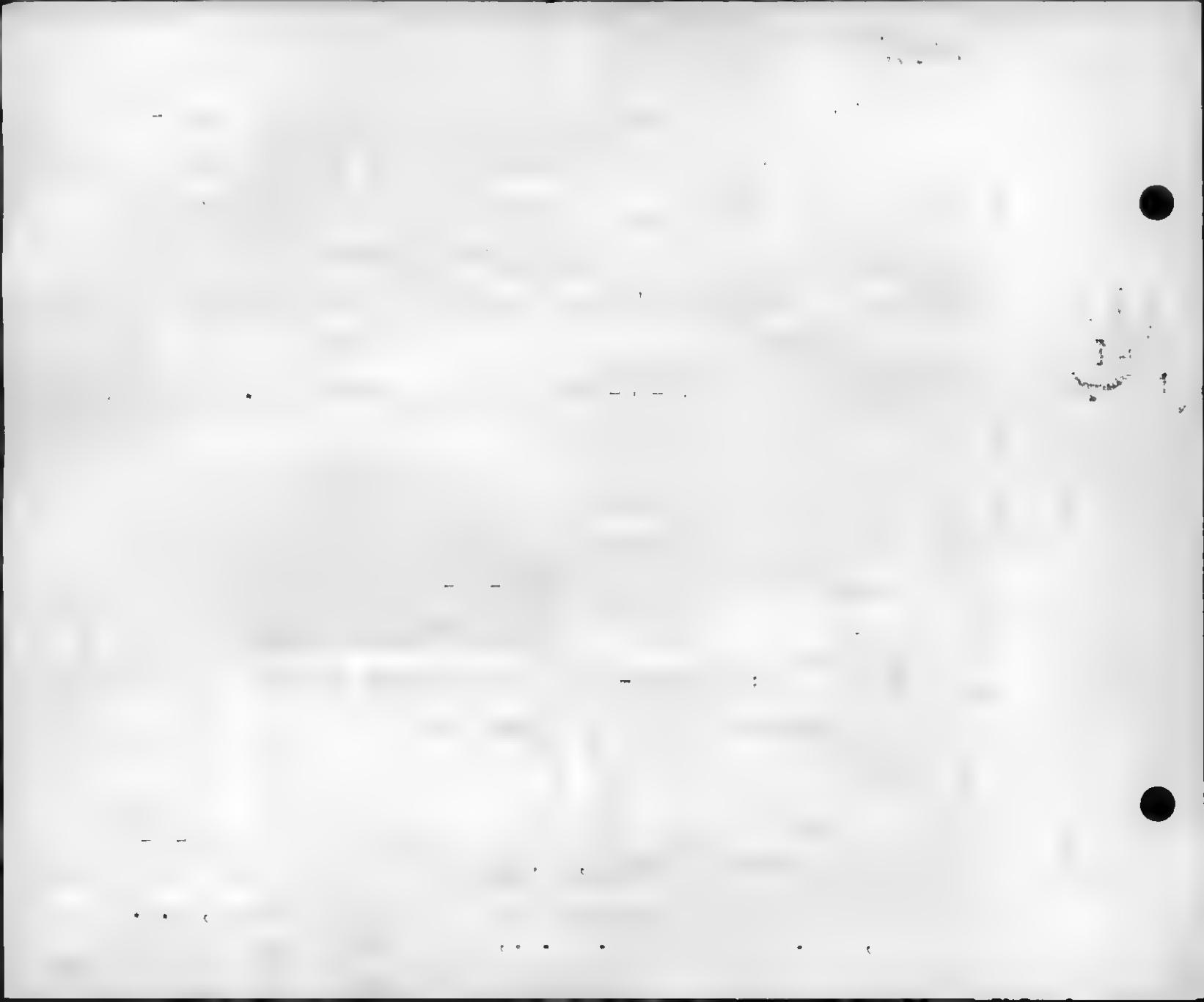


FOR STATE  
HEALTH DEPT

1  
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 72 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil if item 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH										16299	
1. DECEASED NAME (Type or Print)		First	Middle	Last			20. DATE KNOWN OF ESTI- DEATH MATED	Month	Day	Year	2b HOUR
3. SEX	4. RACE	S. DATE OF BIRTH	6. AGE (in years last birthday)	IF UNDER 1 YEAR	H. UNDER 24 HRS		11-12-68			19 9	30am M
Female	Negro	9-12-1894	74 yrs	MONTHS	DAYS	HOURS	Month	Day	Year	2d HOUR	
7a. BIRTHPLACE (State or foreign country)		7b. CIT ZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH			Md	
Maryland		USA					Prince George's				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			2b. KIND OF BUSINESS OR INDUSTRY	
Riverdale			Leland Memorial Hospital				Housewife				
13a. U.S.A. RESIDENCE (Where deceased lived, if institution, Residence before admission) STATE			13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER				
Maryland			Prince George's Upper Marlboro		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		RFD Box 2105				
14. FATHER'S NAME			First	Middle	Last	15. MOTHER'S MARRIED NAME	First	Middle	Last		
			Unknown			Unknown					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO (If yes give war or dates of service)			17. INFORMANT			ADDRESS		
No			218-30-4079A			Hilda Diggs RFD Bx. 2105			Upper Marlboro		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>Cardiac arrest</u> Due to, or as a consequence of <u>Arteriosclerotic heart disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH minutes	
DUE TO, OR AS A CONSEQUENCE OF (c)										unknown	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>Fracture neck of left femur - 10-14-68</u>											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY?					
10-17-68						Fracture neck of legt femur			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. EXTERNA. CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year HOUR AM			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
			4:20am 10-14- 19 68			Fell in bedroom of home					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or RFD No.      City or Town      County      State					
			Bedroom of home			same as #13					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined monner <input type="checkbox"/>											
ACTUAL SIGNATURE										CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type)		John Kehoe MD Riverdale, Md.								ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
23a. BURIAL, CREMATION REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION (City or Town)      (County)      (State)			22b. DATE SIGNED 11-13-68	
Burial		11/16/68		Mount Olivet			Washington, D.C.				
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REG STRAR			25b. REGISTRAR'S SIGNATURE				
Rollins, Inc. 4339 Hunt Pl., N.E., DC							NOV 14 1968			Charles Judge	
VR A15ME (5) 10M REV 1/68											



## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## CERTIFICATE OF DEATH

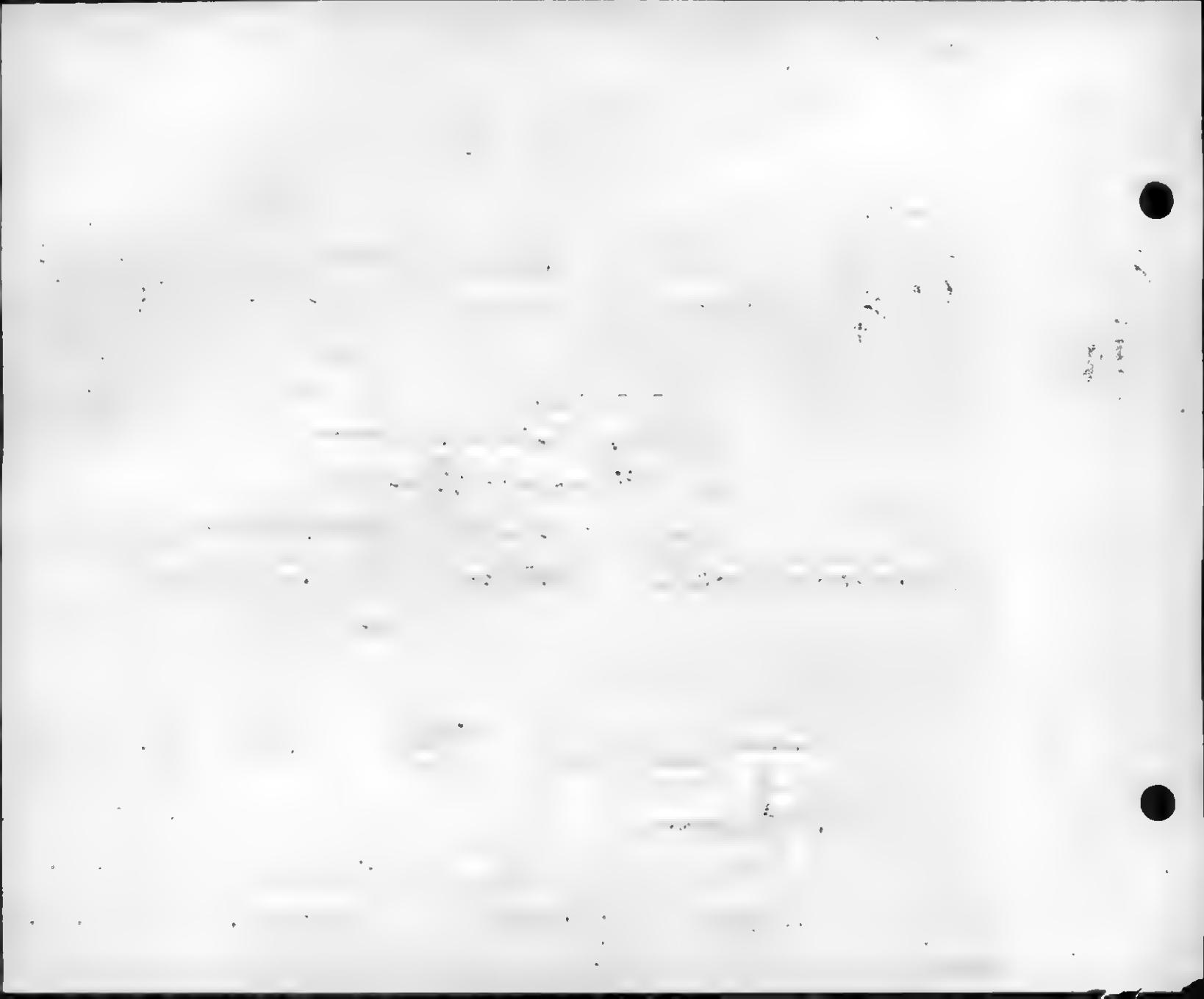
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.  
 Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, please remove carbon paper pages 1 and 2, and file within 24 hours after death.

16286

16286

1. DECEASED-NAME (Type or print)	First Herbert	Middle O.	Last Benson	2a. DATE OF DEATH 11 Month 18 Day 68 Year 10:10am	2b. HOUR 10:10am
3. SEX Male	4. RACE White	5. DATE OF BIRTH 6-16-92		6. AGE (in years last birthday) 76 yrs.	F UNDER 1 YEAR MONTHS DAYS HOURS MIN
7a. BIRTHPLACE (State or foreign country) New York	7b. CITIZEN OF WHAT COUNTRY? USA	B. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Prince George		
10. CITY OR TOWN OF DEATH College Park	11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) 4526 Albion Rd.	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Standard Oil (Retired) Washington		12b. KIND OF BUSINESS OR INDUSTRY News Md.	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Res dence before admission) STATE Maryland	13b. COUNTY Prince George	13c. CITY OR TOWN College Park	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 4526 Albion Rd., College Park	
14. FATHER'S NAME First Alfred	Middle Benson	15. MOTHER'S MAIDEN NAME First Sarah	Middle	Lost	Bennett
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No	16b. SOCIAL SECURITY NO 182-22-8666	17. INFORMANT Medical Records Department			Address
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Septic Pulmonary Edema</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i>4201</i> (b) <i>Or myocardial failure</i> (c) <i>Arterio-venous fistulous</i> <i>fistulous</i> <i>present</i>					
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (c) <i>Carcinoma prostate c metastasis to kidney bladder</i>					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
MEDICAL CERTIFICATION					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED White <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State
22a. I certify that (I) (this hospital) attended the deceased from <i>Nov 19</i> , 19 <i>68</i> , to <i>Nov 19</i> , 19 <i>68</i> , that (I) (we) last saw the deceased alive on <i>Nov 19</i> , 19 <i>68</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <i>W. Etienne</i>	DEGREE ATTENDING PHYS.	MED. DIRECTOR <input checked="" type="checkbox"/>	STAFF PHYS <input type="checkbox"/>	22c. DATE SIGNED 11-18-68	
22d. PHYSICIAN'S NAME (Type)	W. Etienne, M.D.	22e. ADDRESS 4713 Berwyn Rd., College Park, Md.			
23a. BURIAL CREMATION, REMOVAL (Specify) Burial	23b. DATE 11/21/68	23c. NAME OF CEMETERY OR CREMATORIAL Green Hill	23d. LOCATION (City or Town) Waynesboro, Franklin Co., Pa.	(County)	(State)
24. FUNERAL DIRECTOR <i>Walter J. Grove, Waynesboro, Pa.</i>	ADDRESS	25a. RECEIVED BY REGISTRAR NOV 21 1968	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	DATE	



## 10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.  
 To FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper pages 1 and 2 which should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 7 days after death.

I'm 23 Film 6407  
12/3/68 kk  
16287

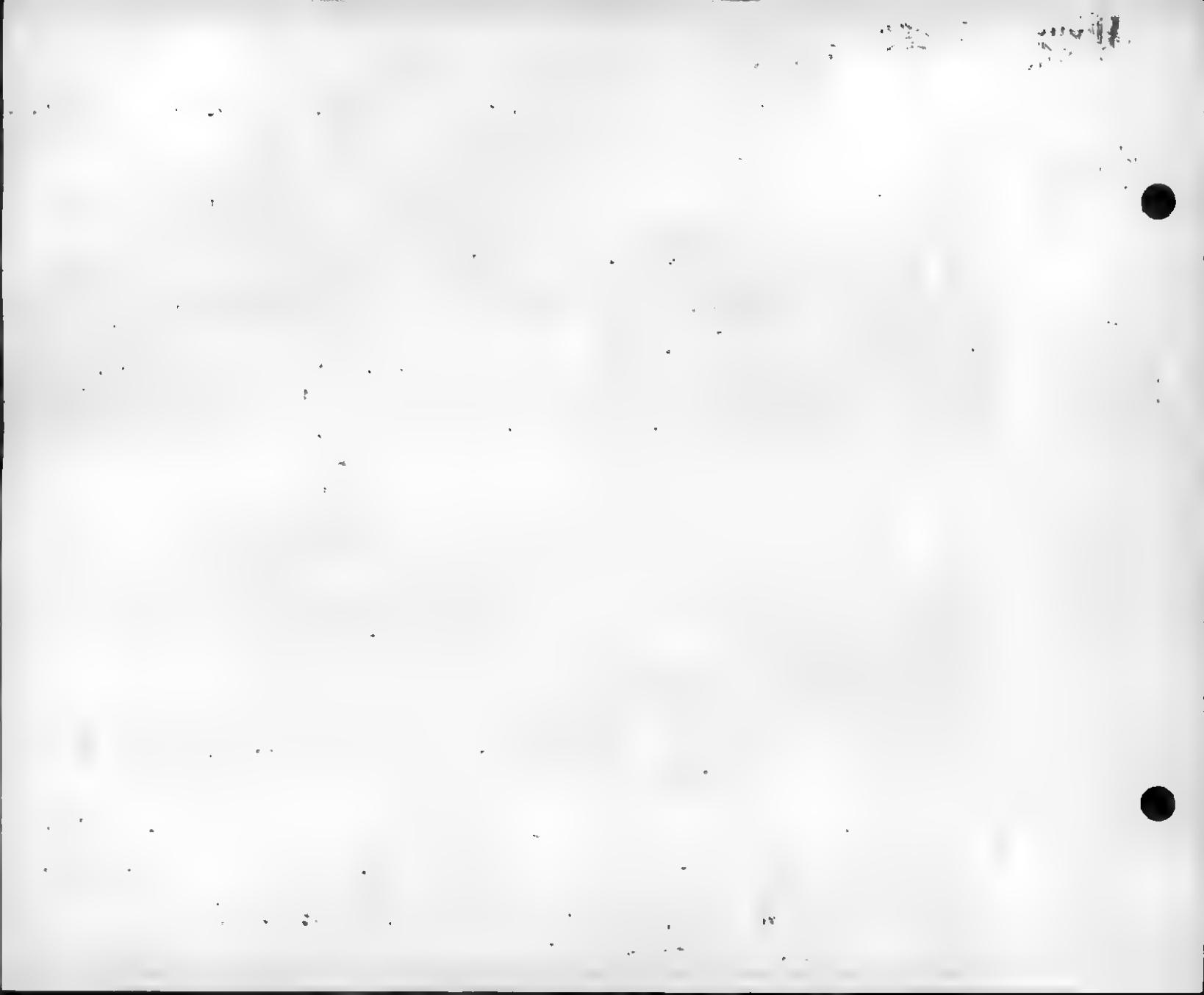
## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16301

## CERTIFICATE OF DEATH

1 DECEASED NAME (Type or print)	First <b>Burt</b>	Middle	Last <b>Black</b>	2d. DATE OF DEATH Month <b>Nov.</b>	Day <b>19, 1968</b>	Year	2b. HOUR <b>6 A.M.</b>
3 SEX <b>Male</b>	4. RACE <b>Negro</b>	S. DATE OF BIRTH <b>July 22, 1914</b>	6 AGE (In years last birthday) <b>54</b>	IF UNDER 1 YEAR MONTHS <b>YRS.</b>	IF UNDER 24 HRS HOURS <b>MIN.</b>		
7a BIRTHPLACE (State or foreign country) <b>So. Car.</b>	7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH <b>Prince George's</b>	Md.			
10 CITY OR TOWN OF DEATH <b>Cheverly</b>	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Prince Geo. Gen'l Hospital</b>	12a JSJAL OCCUPATION (Kind of work done during most of working life, even if retired)	12b KIND OF BUSINESS OR INDUSTRY				
13a USJAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <b>Maryland</b>	13b. CITY OR TOWN <b>Prince George's</b>	13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e STREET AND NUMBER <b>6409 K Street</b>				
14. FATHER'S NAME First <b>Warren</b>	Middle <b>Black</b>	15. MOTHER'S MAIDEN NAME First <b>Ella</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown)	16b. SOCIAL SECURITY NO (If yes give war or dates of service) <b>578-10-6483</b>	17. INFORMANT <b>Daughter</b>	Address <b>1218 H St. N.W. washington D.C.</b>				
18. CAUSE OF DEATH (Enter on one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Bronchogenic Carcinoma, right lung, with metastasis.</b>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
1621 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>1621</b>							
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>	21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (HOME FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State		
22a. I certify that <input type="checkbox"/> (this hospital) attended the deceased from <b>Nov. 13, 1968</b> to <b>Nov. 19, 1968</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>Nov. 19, 1968</b> , and that in <input type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) <input type="checkbox"/> did <input type="checkbox"/> not <input type="checkbox"/> view the body after death							
22b. SIGNATURE <i>Joselito Magday, M.D.</i>						22c. DATE SIGNED <b>Nov. 19, 1968</b>	
22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS <b>Prince Geo. Gen'l Hospital, Cheverly, Md.</b>						
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE <b>23 Nov. 68</b>	23c. NAME OF CEMETERY OR CREMATORIAL <b>Harmony Mem. Cemetery</b>	23d. LOCATION (City or Town) <b>Cheverly, Md.</b>	(County)	(State)		
24. FUNERAL DIRECTOR <b>L &amp; Langford 611/11/68</b>	ADDRESS	25a. RECD BY REGISTRAR <b>NOV 20 1968</b>	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>				



## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 and 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

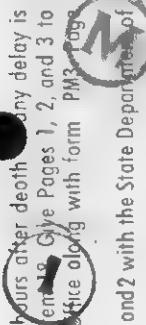
16283

16301

1. DECEASED NAME (Type or print)	First <b>Lillian</b>	Middle <b>B</b>	Last <b>Blaisdell</b>	Lost	2a. DATE OF DEATH Month <b>Nov 15, 1968</b>	Year <b>1968</b>	2b. HOUR <b>1;45 AM</b>				
3. SEX <b>female</b>	4. RACE <b>white</b>	5. DATE OF BIRTH <b>Sept 19, 1868</b>			6. AGE (In years at death) <b>100</b>	IF UND. 1 YEAR YRS. <b>1</b>	IF UND. 24 HRS. MONTHS <b>0</b>	IF UND. 24 HRS. DAYS <b>0</b>	IF UND. 24 HRS. HOURS <b>0</b>	IF UND. 24 HRS. MIN. <b>0</b>	
7a. BIRTHPLACE (State or foreign country) <b>Massachusetts</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED			9. COUNTY OF DEATH <b>Pro Georges</b>			Md.			
10. CITY OR TOWN OF DEATH <b>Adelphi</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Hill Haven rest home</b>			12a. USUAL OCCUPATION (Kind of work done during most of work life, even if retired.) <b>Retired</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>Export Co</b>			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Md</b>	13b. COUNTY <b>Pro Geo</b>	13c. CITY OR TOWN <b>Cheverly</b>	13d. INSIDE CITY LIMIT? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	13e. STREET AND NUMBER <b>6204 Lombard st</b>							
14. FATHER'S NAME First <b>John W Blaisdell</b>	Middle	Last	15. MOTHER'S MAIDEN NAME First <b>Emily Deering</b>			Middle	Last				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <b>no</b>	16b. SOCIAL SECURITY NO.			17. INFORMANT <b>Wm W Blaisdell</b>	Address <b>Cheverly, Md.</b>						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary edema</b> 4124 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a). (b) stating the underlying cause lost <b>arteriosclerotic heart disease</b> (c) <b>anemia, agotemia</b>						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>anemia, agotemia</b>											
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M.      19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)									
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town		County	State					
22a. I certify that (I) (this hospital) attended the deceased from <b>Nov 15, 1968</b> , to <b>Nov 15, 1968</b> , that (II) (we) last saw the deceased alive on <b>Nov 15, 1968</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>John B Cameron</b>	22c. DEGREE ATTENDING PHYS.	<input checked="" type="checkbox"/> MED. DIRECTOR	<input type="checkbox"/> STAFF PHYS.	22d. DATE SIGNED <b>Nov 6, 1968</b>							
22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS										
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>	23b. DATE <b>Nov 15, 1968</b>	23c. NAME OF CEMETERY OR CREMATORIAL <b>Ft Lincoln Crematory</b>	23d. LOCATION (City or Town) <b>Colmar Manor</b>	(County) <b>Pro Geo</b>	(State) <b>Md.</b>						
24. FUNERAL DIRECTOR <b>F. Gasch's Sons</b>	ADDRESS <b>Hyattsville, Md.</b>	25a. REC'D BY REGISTRAR DATE <b>NOV 18 1968</b>	25b. REGISTRAR'S SIGNATURE <b>Charles George</b>								



FOR STATE  
HEALTH DEPT.



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if any delay is necessary; please execute the certificate, writing the word "pending" in pencil in Item 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3 Page 5 may be retained for your files.

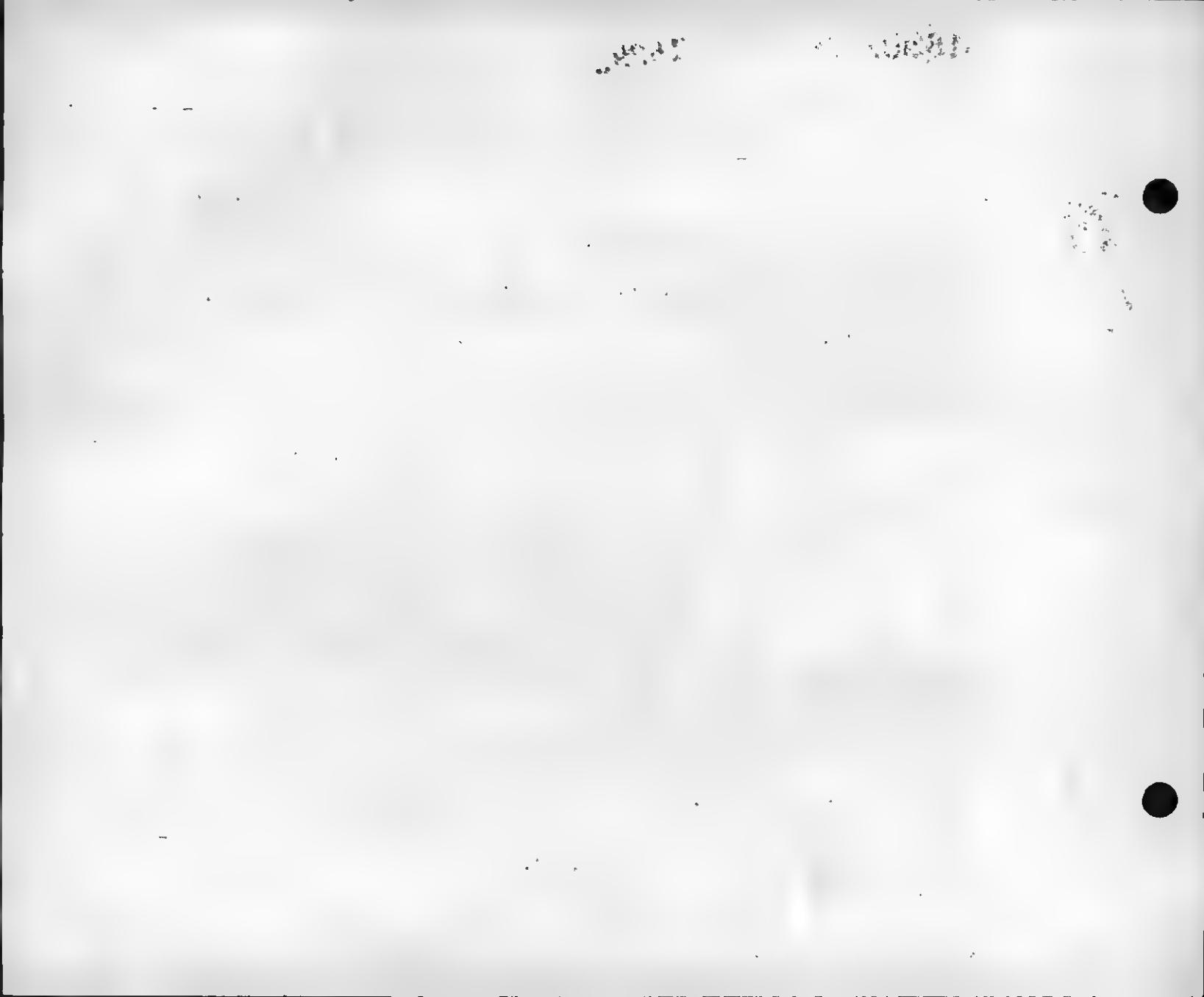
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1630

1 DECEASED NAME (Type or Print)		First	Middle	Last	2a DATE KNOWN OF ESTI- MATED	Month	Day	Year	2b HOUR
Joseph				Bowie	<input checked="" type="checkbox"/> 11-16-68	19	9	50pm	
3 SEX	4 RACE	S DATE OF BIRTH	6 AGE (In years last birthday)	7 IF UNDER 1 YEAR MONTHS DAYS	8 IF UNDER 24 HRS. HOURS MIN.				
Male	Negro	6-7-1877	91 YRS.						
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Pr. Geo. Co. Md.		U.S.A.				Prince George's			
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b KIND OF BUSINESS OR INDUSTRY	
Clinton		Clinton Medical Center							
13a USUAL RESIDENCE (Where deceased lived, if institution admission) STATE		13c CITY OR TOWN		13d INSIDE CITY LIMITS?		13e STREET AND NUMBER			
Maryland		Prince George's Camp Springs		<input type="checkbox"/> YES <input type="checkbox"/> NO		7057 Allentown Road			
14 FATHER'S NAME		First	Middle	Last	15 MOTHER'S MAIDEN NAME	First	Middle	Last	
Bowie, John		H.			Mary	E.	Brace		
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b SOCIAL SECURITY NO. (If yes give war or dates of service)		17. INFORMANT		ADDRESS			
				Roland A. Bowie - Same as above					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart failure									
DUE TO, OR AS A CONSEQUENCE OF Arteriosclerotic heart disease APPROXIMATE INTERVAL Conditions, if any, which gave BETWEEN ONSET AND DEATH rise to immediate cause (a). minutes stating the underlying cause (b) lost									
DUE TO, OR AS A CONSEQUENCE OF over 1 yr (c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
4-105		19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED?				20 AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
MEDICAL CERTIFICATION									
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b)					
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f LOCATION Street or R.F.D. No		City or Town		County	State
22a I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE <i>John Kehoe</i>		EXAMINER'S NAME (Type) John Kehoe MD Riverdale, Md.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> MD ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ADDRESS (Street, city, town, or county)		22b DATE SIGNED 11-17-68			
23a BURIAL, CREMATION, REMOVAL (Specify)		23b DATE Nov. 20/68		23c NAME OF CEMETERY OR CREMATORIAL St. John's Church Cemetery		23d LOCATION (City or Town) Clinton, Pr. Geo. Md.		(County) (State)	
24 FUNERAL DIRECTOR Marcell Adams Aquasco, Md.		ADDRESS		25a REC'D. BY REGISTRAR NOV 25 1968		25b REGISTRAR'S SIGNATURE <i>Charles Juge</i>			



**10 HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

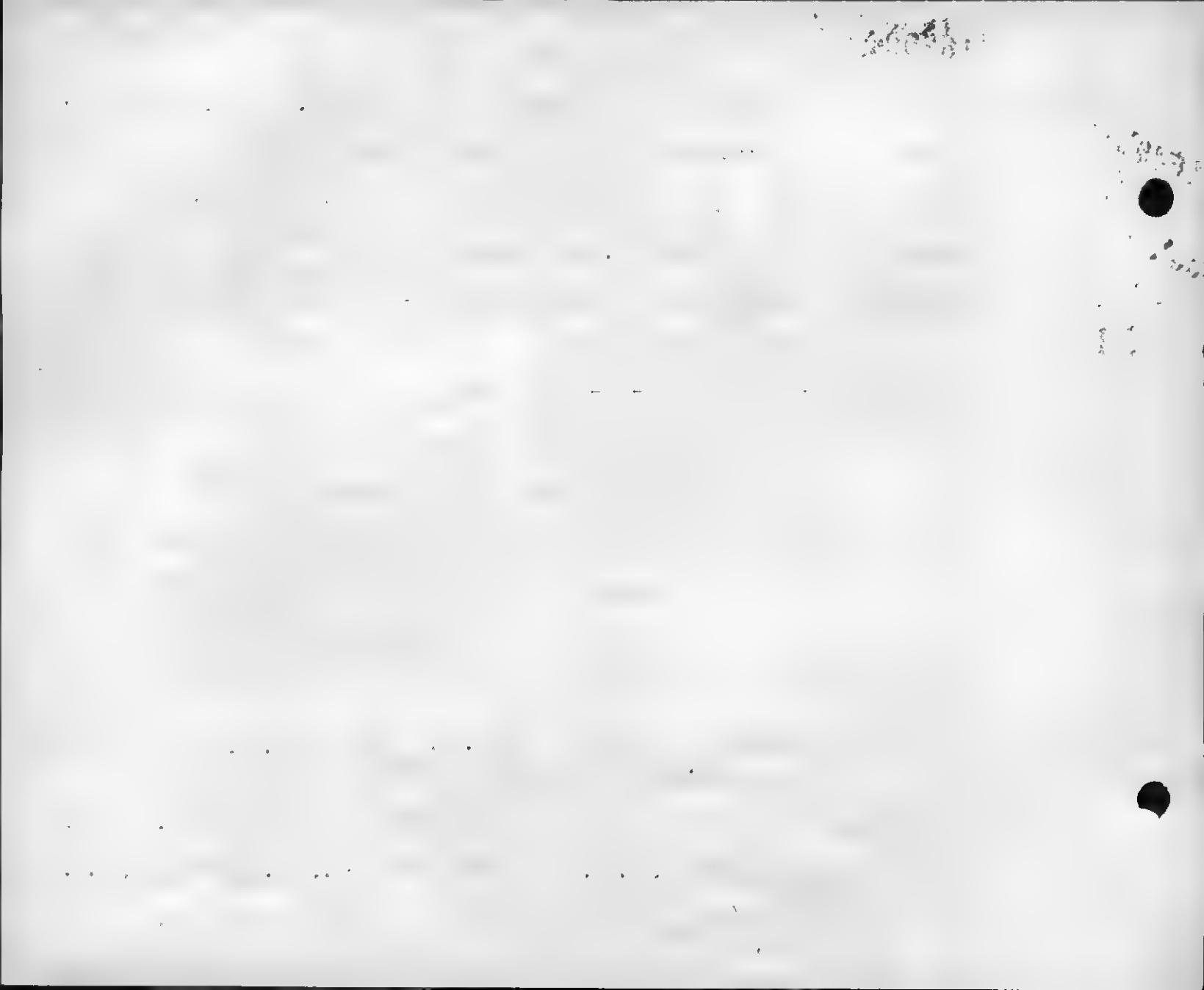
**10 FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal.

**MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201**

**CERTIFICATE OF DEATH**

16304

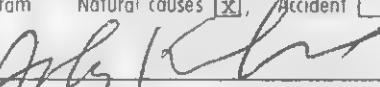
1. DECEASED NAME (Type or print)		First <b>Laura</b>	Middle <b>M.</b>	Last <b>Bowman</b>	2d. DATE OF DEATH Month <b>Nov.</b> Day <b>8,</b> Year <b>1968</b>	26. HOUR <b>6:45 A M</b>	
3. SEX <b>Female</b>		4. RACE <b>Caucasian</b>		S. DATE OF BIRTH <b>March 8, 1887</b>	6. AGE (In years lost birthday) <b>81</b> YRS	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS HOURS MIN
7a. BIRTHPLACE (State or foreign country) <b>Virginia</b>		7b. CITIZEN OF WHAT COUNTRY? <b>J. S. A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH <b>Prince George's</b>		Md
10. CITY OR TOWN OF DEATH <b>Cheverly</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Prince Geo. Gen'l Hospital</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>Cathern Copeland</b>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution admission) STATE <b>Maryland</b>		13b. COUNTY <b>Prince George's</b>	13c. CITY OR TOWN <b>Hyattsville</b>	13d. INSIDE CITY LIMITS? <b>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></b>	13e. STREET AND NUMBER <b>5802 42nd Avenue</b>		
14. FATHER'S NAME First <b>Jacob Boehm</b>		Middle Lost	15. MOTHER'S MAIDEN NAME First Middle <b>Cathern Copeland</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16b. SOCIAL SECURITY NO <b>578-56-7515</b>		17. INFORMANT <b>Roberta L. Bowman</b>	Address (above address)		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Liver neoplasia in farction</i> (Daughter) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause <i>11/10/9</i> (b) <i>Gallbladder calcification</i> (Cancer) DUE TO, OR AS A CONSEQUENCE OF <i>11/10/9</i> (c) <i>Liver - Cancer in stomach</i> (4 months) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>3 hrs. c.</b>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>4. Chronic coronary sclerosis (grave disease 9.2.)</b>							
19a. MEDICAL CERTIFICATION DATE OF OPERATION		19b. CONDITION FOR WHICH OPERAT. ON WAS PERFORMED		20a. AUTOPSY? <b>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></b>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>Yes</b>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify med. col. examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (I) <del>has/had</del> attended the deceased from <b>Nov. 4, 1968</b> to <b>Nov. 8, 1968</b> , that (I) <del>was</del> last saw the deceased alive on <b>Nov. 8, 1968</b> , and that in (my) <del>my</del> opinion death occurred on the date and hour and from the causes stated above, (I) <del>did/did not</del> view the body after death.							
22b. SIGNATURE <i>Saul Schwartzbach, M. D.</i>		22c. DEGREE <b>MD</b>	ATTENDING PHYS <b>XX</b>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS <input type="checkbox"/>	22d. DATE SIGNED <b>Nov. 8, 1968</b>	
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS <b>106 Irving St., NW, Washington, D.C.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>11/11/68</b>	23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS <b>Massanutton Cem. Rainier, Maryland</b>		23d. LOCATION (City or Town) (County) (State)		
24. FUNERAL DIRECTOR Name <b>Nalton's Funeral Home Inc.</b>				25a. REC'D BY REGISTRAR <b>Charles Judge</b>	25b. REGISTRAR'S SIGNATURE		
				DATE <b>NOV 14 1968</b>			



FOR STATE  
HEALTH DEPT.

Items 13&22a Film 409 MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
**1629** MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1630.

1 DECEASED NAME (Type or Print)		First	Middle	Last	2a DATE KNOWN OF ESTI- DEATH MATED	Month Day Year	2b HOUR
Regina		Dawn	Bradley		11-17-68 1977		00am
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (in years last birthday)	F UNDER 1 YEAR	G UNDER 24 HRS		
Female	White	8-27-1968	YRS. 2	MONTHS 21	HOURS	MIN	2c DATE PRONOUNCED DEAD
7a. BIRTHPLACE (State or foreign country) W. Va.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9 COUNTY OF DEATH	
10 CITY OR TOWN OF DEATH Cheverly		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Prince George Hospital		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b KIND OF BUSINESS OR INDUSTRY	
13a USUAL RESIDENCE (Where deceased lived, if institution Reside before admission) STATE Maryland		13c CITY OR TOWN Prince George's Suitland	13d INSIDE CITY LIMITS?	13e STREET AND NUMBER			
14 FATHER'S NAME First Joe Middle E. Last Bradley		15 MOTHER'S MAIDEN NAME Norma		Middle		Last Shaver	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No or unknown)		16b SOCIAL SECURITY NO. --		17. INFORMANT Joe J. Bradley		ADDRESS 4656 Homer Ave.	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) SMI 795X DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) SMI DUE TO, OR AS A CONSEQUENCE OF (c)  PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED?				20 AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a EXTERNA. CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19	21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (At home, farm, street factory, office building, etc.)	21f LOCATION Street or R.F.D. No		City or Town	County	State
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE 		MD		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22b DATE SIGNED 11-18-68	
EXAMINER'S NAME (Type) John Kehoe MD		Riverdale, Md.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
23a BURIAL CREMATION, REMOVAL (Specify) Burial		23b DATE 11-20-68	23c NAME OF CEMETERY OR CREMATORIUM Bradley Cemetery		23d LOCATION (City or Town) Lindside		(County) W. Va. (State)
24 FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR Mervin 21 1958		25b. REGISTRAR'S SIGNATURE	
Wilhelm Funeral Home 1308 Suitland Pd. S. E.							

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. File Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 5 may be retained for your files.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

17.31

20.3

**FOR STATE  
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed with in 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

**MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

16306

1. DECEASED NAME (Type or Print)		First <b>Allen</b>	Middle <b>Eugene</b>	Last <b>Bridges</b>	2a DATE KNOWN OF ESTI- DEATH MADE <input checked="" type="checkbox"/> <b>11-6-68</b>	Month <b>195</b>	Day <b>30pm</b>	Year <b>1968</b>	2b HOUR <b>195:30pm</b>		
3 SEX <b>Male</b>	4 RACE <b>White</b>	5 DATE OF BIRTH <b>12-11-1931</b>	6 AGE (in years last birthday) <b>36</b>	7 IF UNDER 1 YEAR MONTHS <b>YRS</b>	8 IF UNDER 24 HRS HOURS <b>MIN.</b>						
7a BIRTHPLACE (State or foreign country) <b>North Carolina</b>		7b CITIZEN OF WHAT COUNTRY? <b>USA</b>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		9 COUNTY OF DEATH <b>Prince George's</b>		2c DATE PRONONCED DEAD Month <b>11</b>			
10 CITY OR TOWN OF DEATH <b>Bladensburg</b>		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>4205 57th. Avenue</b>			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>Policeman</b>			12b KIND OF BUSINESS OR INDUSTRY			
13a USUAL RESIDENCE (Where deceasedived, if institution before admission) STATE <b>North Carolina</b>		13b COUNTY		13c CITY OR TOWN <b>Dallas</b>		13d INSIDE CITY LIMIT <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		13e STREET AND NUMBER <b>Rt. 1, Box 492</b>			
14 FATHER'S NAME <b>Odell Bridges</b>		First	Middle	Last	15. MOTHER'S MAIDEN NAME <b>Mary Lee Jenkins</b>						
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16b. SOCIAL SECURITY NO. (If yes give war or dates of service) <b>241-46-1647</b>		17 INFORMANT <b>Patricia Lynne Bridges (wife)</b>		ADDRESS					
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
<p>18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))</p> <p>PART I. DEATH WAS CAUSED BY:</p> <p>IMMEDIATE CAUSE (a) <b>Gun shot wound of head</b></p> <p>155X Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause last</p> <p>(b) DUE TO, OR AS A CONSEQUENCE OF</p> <p>(c) DUE TO, OR AS A CONSEQUENCE OF</p>											
<p>PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)</p> <p>776X</p>											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?					20 ALTOPSY?			
21a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b TIME OF INJURY Month, Day, Year HOUR A.M. <b>5:30pm P.M. 11-6-1968</b>			21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) <b>Shot self in head with Cal. revolver.</b>			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>			21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.) <b>4205 57th. Avenue, Bladensburg, Prince George Co., Maryland</b>			21f LOCATION Street or R.F.D. No City or Town County State					
<p>22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input type="checkbox"/>, and in my opinion death resulted from Natural causes <input type="checkbox"/>, Accident <input type="checkbox"/>, Suicide <input checked="" type="checkbox"/>, Homicide <input type="checkbox"/>, Undetermined manner <input type="checkbox"/></p> <p>ACTUAL SIGNATURE <i>John Kehoe</i></p> <p>EXAMINER'S NAME (Type) <b>John Kehoe MD Riverdale, Md.</b></p>											
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			23b DATE <b>11/9/68</b>			23c NAME OF CEMETERY OR CREMATORIAL <b>Hollywood</b>			23d LOCATION (City or Town) (County) (State) <b>Gastonia, North Carolina</b>		
24 FUNERAL DIRECTOR <b>Wash. Metro Funeral Service</b>			Box 1195 Falls Church, Va.			25a. RECD BY REGISTRAR <b>NOV 14 1968</b>			25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		

16.202

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if necessary; please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 1 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial/transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal and in any event within 72 hours after death.

16293

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

16293

1 DECEASED NAME (Type or Print)		First	Middle	Last	2a DATE KNOWN OF ESTI. DEATH MATED	Month	Day	Year	2b HOUR	
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (In years last birthday)	7 IF UNDER 1 YEAR MONTHS	8 IF UNDER 24 HRS DAYS	9 HOURS	10 MIN			
Male	Negro	3-4-1891	77 YRS							
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH		
West Va.		USA						Prince George's		
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not a hospital give street address)				12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)				12b KIND OF BUSINESS OR INDUSTRY
Glenn Dale		Glenn Dale Hospital								Md
13a USUAL RESIDENCE (Where deceased lived if institution Residence before admission) STATE		13c CITY OR TOWN		13d INSIDE CITY LIMITS?		13e STREET AND NUMBER				
District of Columbia		Washington		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		5040 Lee Street N.E.				
14 FATHER'S NAME		First	Middle	Last	15. MOTHER'S MAIDEN NAME	First	Middle	Last		
Peter				Brooks	Louise			Willis		
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS				
No						Leo Brooks - same as above				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Bilateral hemothorax DUE TO, OR AS A CONSEQUENCE OF Multiple rib fractures										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) DUE TO, OR AS A CONSEQUENCE OF (c)										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?				
21a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b TIME OF INJURY Month, Day, Year HOUR A.M.		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b)						
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e PLACE OF INJURY (At home, farm, street, - factory, office building, etc.) Glenn Dale Hospital, Glenn Dale, Prince George County, Maryland		21f LOCATION Street or R.F.D. No.		City or Town	County	State		
22a I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspect on <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/>										22b DATE SIGNED
ACTUAL SIGNATURE		<i>John Kehoe</i>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				
EXAMINER'S NAME (Type)		John Kehoe MD Riverdale, Md.				M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				
23a CEREMONY, CREMATION, REMOVAL (Specify)		23b DATE		23c NAME OF CEMETERY OR CREMATORIAL ADDRESS		23d LOCATION (City or Town) (County) (State)				
11-21-1968		11-21-1968		Mt Olivet Cem		Bladensburg, Md. D.C.				
24 FUNERAL DIRECTOR		ADDRESS				25a REC'D. BY REGISTRAR DATE	25b REC'D. BY REGISTRAR DATE			
Henry S. Washington & Sons - 4925 Deanwood N.E.						NOV 25 1968				

18. 271

178

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1636

**10 HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician  
**10 FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician or director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 DECEASED NAME (Type or print)		First Annie	Middle J.	Lost Brown	2d. DATE OF DEATH Month Nov. Day 26, Year 1968	2b. HOUR P. 6:15 M
3 SEX Female	4 RACE Colored	5 DATE OF BIRTH 11/22/76		6 AGE (in years last birthday) 92 yrs.	IF UNDER 1 YEAR MONTHS 0 DAYS HOURS 0 MIN	
7a BIRTHPLACE (State or foreign country) Prince Geo. Md.	7b CIT. ZEN OF WHAT COUNTRY? U.S.A.	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Prince George's		
10 CITY OR TOWN OF DEATH Cheverly	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Prince George's General		12a USJA. OCCUPAT ON (Kind of work done during most of working life, even if retired) Naylor		12b KIND OF BUSINESS OR INDUSTRY Md.	
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Md.	13b. COUNTY Pr. Geo's.	13c. CITY OR TOWN Naylor	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER Box 3693		
14 FATHER'S NAME George Middleton	First Middle Last	15 MOTHER'S MAIDEN NAME Henretta	16 Address Ruth Harper 1406 Brooks Rd. S.E. Wash. D.C.	Middle Dotson	Lost	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <input type="checkbox"/>	16b. SOCIAL SECURITY NO (If yes give war or dates of service) 214-58-2308	17 INFORMANT Ruth Harper	APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) <u>Malnutrition, dehydration</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>CVA - which made food intake infuse</u>						
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) None						
19a. DATE OF OPERATION 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No	City or Town	County	State	
22a. I certify that (I) (this hospital) attended the deceased from <u>10/21</u> , 19 <u>68</u> , to <u>11/26</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>11/26</u> , 19 <u>68</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death						
22b. SIGNATURE <u>Brian</u>	DEGREE ATTENDING PHYS.	<input type="checkbox"/>	MED. DIRECTOR	<input type="checkbox"/>	STAFF PHYS	<input type="checkbox"/>
22c. DATE SIGNED						
22d. PHYSICIAN'S NAME (Type) Pr. Geo. Gen Hosp. Cheverly, Md.	22e. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 11-30-68	23c. NAME OF CEMETERY OR CREMATORIAL Nottingham-Creome Cem.	23d. LOCATION (City or Town) Pr. Geo. Co., Md.		(County) (State)	
24. FUNERAL DIRECTOR Martell Williams Liguasco, Md.	ADDRESS	25a. REC'D BY REGISTRAR DEC 3 1968	25b. REGISTRAR'S SIGNATURE Charles Judge			
VR A15 45M - 1						

812-12-1381

## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

1636

16293

## CERTIFICATE OF DEATH

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician, page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

1. DECEASED NAME (Type or print)	First Irving	Middle F.	Last Brown	2a. DATE OF DEATH Month 11	2b. HOUR Doy 25 Year 68 4:15 M
3 SEX Male	4 RACE White	S. DATE OF BIRTH 7/8/21	6. AGE (in years lost birthday) 47 YRS.	1f UNDER 1 YEAR MONTHS	1f UNDER 24 HRS. HOURS
7a. BIRTHPLACE (State or foreign country) Maryland	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	9. COUNTY OF DEATH Prince George's County, Md. Md.		
10. CITY OR TOWN OF DEATH Glenn Dale	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Glenn Dale Hosp.	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Law Clerk	12b. KIND OF BUSINESS OR INDUSTRY --		
13a. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) STATE D.C.	13c. CITY OR TOWN Washington	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 815 5th Street, N. W.		
14. FATHER'S NAME Dorsey	First Middle Brown	15. MOTHER'S MAIDEN NAME First Daisey	Middle Last Gregg		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown yes	16b. SOCIAL SECURITY NO 1943-1949	17. INFORMANT Decedent	Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>O.I.I.d</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH months	
(b) DUE TO, OR AS A CONSEQUENCE OF <i>Pulmonary tuberculosis, far advanced, active</i>					
(c) DUE TO, OR AS A CONSEQUENCE OF <i>Pulmonary tuberculosis, far advanced, active</i>				17 years	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)					
<b>Right pneumonectomy, 1960, with bronchopleural cutaneous fistula</b>					
MEDICAL CERTIFICATION	19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
	21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b)		
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE, BUILDING, ETC.)	21f. LOCATION Street or RFD No	City or Town	County	State
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>2/2/</u> , 19 <u>66</u> , to <u>11/25</u> , 19 <u>68</u> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>11/25/</u> 19 <u>68</u> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) <input type="checkbox"/> (do not) view the body after death.					
22b. SIGNATURE <i>Moe Weiss</i>	DEGREE ATTENDING PHYS.	<input type="checkbox"/> MED DIRECTOR	<input checked="" type="checkbox"/> STAFF PHYS	22c. DATE SIGNED 11/25/68	
22d. PHYSICIAN'S NAME (Type) Moe Weiss, M.D.	22e. ADDRESS Glenn Dale Hospital Glenn Dale, Maryland				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE Nov. 28, 1968	23c. NAME OF CEMETERY OR CREMATORIAL Mt. View	23d. LOCATION (City or Town) Purdum, Md.	(County)	(State)
24. FUNERAL DIRECTOR Olin L. Molesworth, Damascus, Md.	ADDRESS	25a. REC'D BY REGISTRAR DATE DEC 2 1968	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		



MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

1051

CERTIFICATE OF DEATH

**10 HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.  
 Page 4 may be retained by the hospital or attending physician.

**10 FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 DECEASED NAME (Type or print)				First	Middle	Last	2a DATE OF DEATH		2b HOUR			
STEVEN COURTEMAY BROWNE							NOV	Month 29 Day 68 Year	7:08 M			
3 SEX		4. RACE		5. DATE OF BIRTH			6. AGE (In years lost birthday)		IF UNDER 1 YEAR			
MALE		CAUC		5 OCT 68			YRS.		MONTHS DAYS HOURS MIN			
7a BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED		XX		9. COUNTY OF DEATH				
MARYLAND		U.S.A.		WIDOWED		<input type="checkbox"/> DIVORCED		PRINCE GEORGES		Md		
10 CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY			
ANDREWS AFB			MALCOLM GROW USAFHOSP			NA						
13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)			13c CITY OR TOWN			13d. INSIDE CITY LIMITS?			13e STREET AND NUMBER			
STATE MARYLAND			PRINCE GEORGES FORESTVILLE			EX NO <input type="checkbox"/>			4425 RENA RD APT 102			
14. FATHER'S NAME First			Middle			Last			15. MOTHER'S MAIDEN NAME First Middle Last			
WALTER COURTEWAY BROWNE									PATRICIA JEAN ROBINSON			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, No, or Unknown			16b. SOCIAL SECURITY NO.			17 INFORMANT			Address			
(If yes give war or dates of service)			NA			Father Same as item #13						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))												
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Aspiration, terminal of gastric contents</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH												
911 X DUE TO, OR AS A CONSEQUENCE OF												
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)												
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) 921.9												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
YES <input checked="" type="checkbox"/>						NO <input type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b)								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County		State		
22a. I certify that ( <input checked="" type="checkbox"/> ) (this hospital) attended the deceased from <u>11-19</u> , 19 <u>68</u> , to <u>11-19</u> , 19 <u>68</u> , that ( <u>I</u> ) ( <u>we</u> ) last saw the deceased alive on <u>19</u> , and that in ( <u>my</u> ) ( <u>our</u> ) opinion death occurred on the date and hour and from the causes stated above, ( <u>I</u> ) ( <u>we</u> ) ( <u>did</u> ) ( <u>did not</u> ) view the body after death.												
22b. SIGNATURE <u>John Goodman, M.D.</u> 22c. DATE SIGNED <u>29 Nov. 68</u>												
22d. PHYSICIAN'S NAME JOHN GOODMAN,		22e ADDRESS MALCOLM GROW USAFHOSP.										
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 12-2-68		23c. NAME OF CEMETERY OR CREMATORIAL Druid Ridge			23d. LOCATION (City or Town) Pikesville		(County) Balto.		(State) Md.	
24. FUNERAL DIRECTOR H.W. Jenkins & Sons Co.		ADDRESS 4905 York Rd. Balto., Md.				25a. REC'D BY REGISTRAR DEC 2 1968		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>				
30M REV. 1/68												



## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

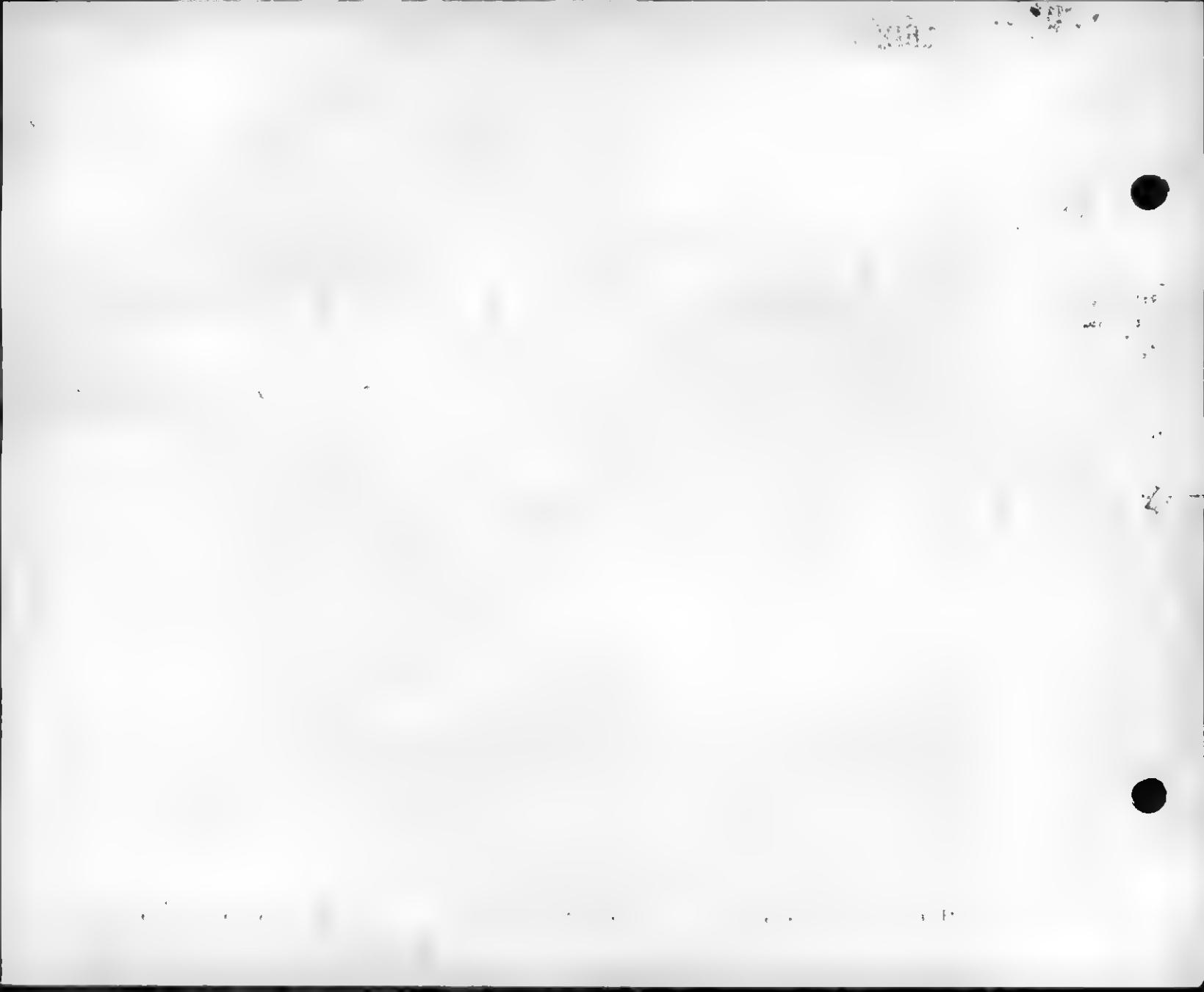
## CERTIFICATE OF DEATH

1631

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.  
**Page 4 may be retained by the hospital or attending physician.**

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in, it may be retained by the funeral director; page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper pages 1 and 2, and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

1 DECEASED NAME (Type or print)	First	Middle	Last	2a. DATE OF DEATH Month	Day	Year	2b. HOUR 4:20 P.M.		
<b>CARRIE F BUCKLER</b>				11	1	68			
3 SEX <b>Female</b>	4 RACE <b>white</b>	S DATE OF BIRTH <b>10/8/91</b>	5	6. AGE (in years last birthday) <b>77</b> YRS.	IF UNDER 1 YEAR MONTHS	DAYS	IF UNDER 24 HRS. HOURS	MIN.	
7a BIRTHPLACE (State or foreign country) <b>MD.</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	B. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH <b>P.Geo.</b>					Md.	
10 CITY OR TOWN OF DEATH <b>Clinton MD</b>	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Pineview Gardens</b>		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>Housewife</b>	12b KIND OF BUSINESS OR INDUSTRY					
13a USUAL RESIDENCE (Where deceased lived if institution admission) STATE <b>Pineview Home 13 Ryan's Road</b>	13c. CITY OR TOWN <b>MD</b>	13d INSIDE CITY LIM 15? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e STREET AND NUMBER <b>12C Fraser Rd</b>						
14. FATHER'S NAME First <b>JAMES QUADE</b>	Middle	Last	15. MOTHER'S MAIDEN NAME First <b>JANE M. LACEY</b>	Middle	Last				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) <b>No</b>	16b. SOCIAL SECURITY NO <b>214-12-87770</b>	17 INFORMANT <b>Mildred Hodges (daughter)</b>	Address <b>Same as mother</b>						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Circulatory collapse</b> <b>4119</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) <b>coronary insufficiency</b> DUE TO, OR AS A CONSEQUENCE OF <b>Diabetes mellitus &amp; cerebral arteriosclerosis</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>8 days</b>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>4</b>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, not by medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>	21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY OFFICE BUILDING, ETC.)	21f LOCATION Street or R.F.D. No	City or Town		County	State		
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death									
22b. SIGNATURE <b>Alfred R. Lapan</b>		DEGREE <b>MD</b>	ATTENDING PHYS. <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22c. DATE SIGNED <b>CLINTON, MD</b>					
22d. PHYSICIAN'S NAME (Type) <b>ALFRED R. LAPAN, MD</b>	23c. ADDRESS <b>CLINTON, MD</b>								
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE <b>Nov. 4, 1968</b>	23c. NAME OF CEMETERY OR CREMATORIAL <b>ST. JOSEPH'S</b>	23d. LOCATION (City or Town) <b>MORGANZA, ST. MARY'S, MARYLAND</b>	(County)	(State)				
24. FUNERAL DIRECTOR <b>W. Clarke Mattingly - P.M.</b>	ADDRESS <b>100 Main Street, Clinton, MD</b>	25a. REC'D BY REG. STRK. <b>NOV 6 1968</b>	25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>						



MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE  
HEALTH, DEPT.

16298

1031

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3 Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

14

1 DECEASED-NAME (Type or Print)			First John	Middle Joseph	Last Buckley	2a DATE KNOWN OF ESTI- DEATH MATED <input checked="" type="checkbox"/>	Month 11	Day 27	Year 1968	2b HOUR 8:48am M
3 SEX Male	4 RACE White	5 DATE OF BIRTH 3-20-1897	6 AGE (In years last birthday) 71 yrs	7 IF UNDER 1 YEAR MONTHS 0	8 IF UNDER 24 HRS DAYS 0	9c DATE PRONOUNCED DEAD Month 11	Day 27	Year 1968	2d HOUR 8:54am M	
7a BIRTHPLACE (State or foreign country) Connecticut		7b CITIZEN OF WHAT COUNTRY? U S A		8 MARRIED <input type="checkbox"/>	NEVER MARRIED <input type="checkbox"/>	9 COUNTY OF DEATH Prince George's				
10. CITY OR TOWN OF DEATH Cheverly			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Prince George Hospital			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Retired engineer			12b KIND OF BUSINESS OR INDUSTRY U S Gov't	
13a USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) Maryland			13c CITY OR TOWN Prince George's Cheverly			13d INSIDE CITY LIMITS YES <input type="checkbox"/> NO <input type="checkbox"/>			13e STREET AND NUMBER 5397 Quincy St. Apt. #1	
14. FATHER'S NAME John J Buckley sr			15. MOTHER'S MAIDEN NAME Margaret Fitzgerald							
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			16b SOCIAL SECURITY NO 216 44 3117			17 INFORMANT Mary M Cochran			ADDRESS Cheverly, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)). PART I DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>Heart failure</u>			DUE TO, OR AS A CONSEQUENCE OF <u>Arteriosclerotic heart disease</u>						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH minutes over 7 yrs.	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last			(b)			(c)				
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)										
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED?			20 AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)						
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f LOCATION Street or R.F.D. No		City or Town		County	State	
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspect an <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>										
ACTUAL SIGNATURE <i>John Kehoe</i>		EXAMINER'S NAME (Type) John Kehoe MD		CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22b DATE SIGNED 11-27-68		
23a BURIAL, CREMATION, REMOVAL (Specify) Burial		23b DATE Nov 30, 1968		23c NAME OF CEMETERY OR CREMATORIAL Mt Olivet Cemetery		23d LOCATION (City or Town) Washington D. C.		(County) (State)		
24 FUNERAL DIRECTOR F. Gasch's Sons		ADDRESS Hyattsville, Md.		25a REC'D BY REGISTRAR DEC 2 1968		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>				

17-2425

**44** 10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

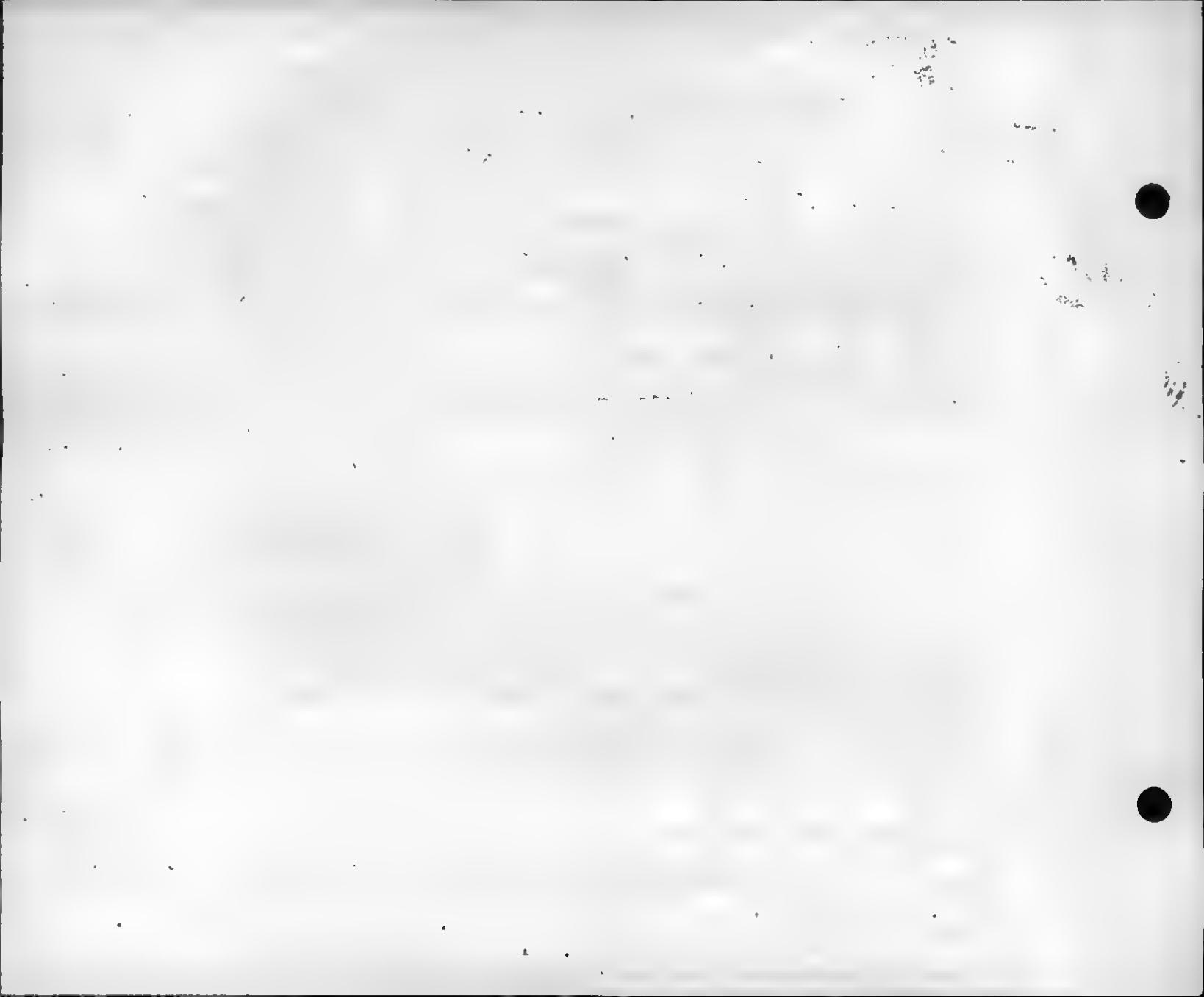
Page 4 may be retained by the hospital or attending physician.  
10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16513

CERTIFICATE OF DEATH

1. DECEASED NAME (Type or print)	First <i>John</i>	Middle <i>W.</i>	Last <i>Bush</i>	2a. DATE OF DEATH Month <i>November</i>	Day <i>18</i>	Year <i>1968</i>	2b. HOUR <i>10 A.M.</i>
3. SEX <i>Male</i>	4. RACE <i>White</i>	S. DATE OF BIRTH <i>6/22/1833</i>	6. AGE (In years lost birthday) <i>75 yrs</i>	IF UNDER 1 YEAR MONTHS <i>0</i>		IF UNDER 24 HRS MONTHS <i>0</i>	
7a. BIRTHPLACE (State or foreign country) <i>Dash., D.C. U.S.A.</i>	7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH <i>Prince George's</i>	Md			
10. CITY OR TOWN OF DEATH <i>Mt Rainier</i>	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>3001 Shepherd</i>	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Ret.-Ft. Lincoln Co.</i>	12b. KIND OF BUSINESS OR INDUSTRY <i>-</i>				
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE <i>Maryland</i>	13b. COUNTY <i>Prince George's</i>	13c. CITY OR TOWN <i>Mt Rainier</i>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER <i>3001 Shepherd Street</i>			
14. FATHER'S NAME First <i>John W. Bush</i>	Middle <i></i>	Last <i></i>	15. MOTHER'S MAIDEN NAME First <i>Ellen O'Prey</i>	Middle <i></i>	Last <i></i>	Address <i>above address</i>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <i>No</i>	16b. SOCIAL SECURITY NO <i>709-09-0877</i>	17. INFORMANT <i>Elizabeth B. Bush</i>	APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>immediate</i>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>massive myocardial infarction</i> (wife) due to, or as a consequence of <i>100</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>occasional hypertensive state</i> 5/2 years due to, or as a consequence of (c)							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)							
19a. DATE OF OPERATION <i>7-1</i>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>none</i>	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) <i>at work</i>		21b. TIME OF INJURY Hour A.M. Month Day Year <i>P.M. 19</i>	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) <i></i>				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At HOME, FARM, STREET, FACTORY, (OFFICE BUILDING, ETC.) <i></i>	21f. LOCATION Street or RFD No. <i></i>	City or Town <i></i>	County <i></i>	State <i></i>	
22a. I certify that (I) (this hospital) attended the deceased from <i>Feb.</i> , 1968, to <i>Nov. 16</i> , 1968, that (I) (we) last saw the deceased alive on <i>Nov. 16</i> , 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>Frank R. Shea M.D.</i>		DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22c. DATE SIGNED <i>Nov. 18, 1968</i>				
22d. PHYSICIAN'S NAME (Type) <i>FRANK R. SHEA</i>		22e. ADDRESS <i>4100-22nd St. N.E. D.C. 20016</i>					
23a. BURIAL, CREMATION, REMOVAL Specified <i>Purist</i>	23b. DATE <i>11/21/68</i>	23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS <i>Ft. Lincoln Cemetery Mt. Rainier, Maryland</i>	23d. LOCATION (City or Town) <i>Colmar Manor, Md.</i>	(County) <i></i>	(State) <i></i>		
24. FUNERAL DIRECTOR <i>Nalley's Funeral Home Inc.</i>	ADDRESS <i>11. Rainier, Maryland</i>	25a. REC'D BY REGISTRAR DATE <i>NOV 25 1968</i>	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>				
VR A15 M 30M REV. 1							



## MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16300

## CERTIFICATE OF DEATH

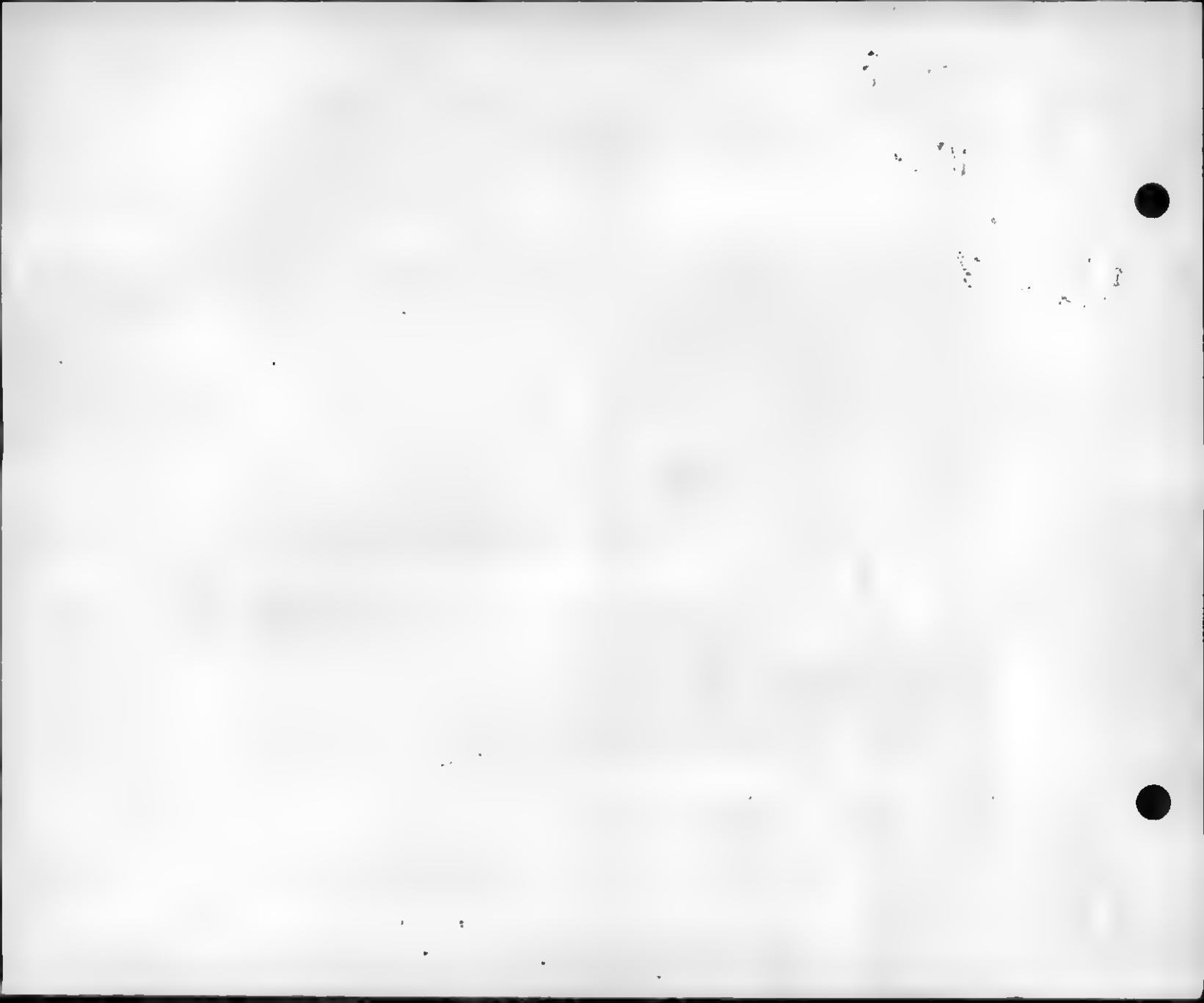
16300

**10 HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Prince George</b>		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>Maryland</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Morningside</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Morningside</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		d. STREET ADDRESS <b>222 Woodland Road</b>		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <b>JOSEPH W. CALDWELL</b>		4. DATE OF DEATH <b>11-20 1968</b>	Month Day Year	
S. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED WIDOWED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <b>Oct. 30, 1906</b>	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Manager Auto Body Shop</b>		10b KIND OF BUSINESS OR INDSTRY	9. AGE (In years 1st-birthday) <b>62 yrs</b>	
13. FATHER'S NAME <b>Charles Caldwell</b>		11. BIRTHPLACE (County & State or foreign country) <b>Washington D. C.</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO <b>18</b>	17. INFORMANT Address <b>Alberta .. Caldwell 222 Woodland Rd.</b>	
IB. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)  Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO  / X <b>Carcinoma of Bladder with Metastases to lungs, Mediastinum &amp; Brain</b>				
INTERVAL BETWEEN ONSET AND DEATH				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				
18. MEDICAL CERTIFICATION 20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)  <b>Oct</b>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) <b>550 Gold Silver Hill Rd, Suitland Md.</b>	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>Oct 5. 1968</b> to <b>Nov 20, 1968</b> , that (I) (we) last saw the deceased alive on <b>Oct 18, 1968</b> , and that death occurred at <b>91 M</b> , from causes and on the date stated above.		22b. DATE SIGNED <b>11-20-68</b>		
22a. SIGNATURE <b>JOHN F. SHAY</b>		ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>
22c. PHYSICIAN'S NAME (Type) <b>JOHN F. SHAY</b>		22d. ADDRESS		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>11-23-68</b>		23c. NAME OF CEMETERY OR CREMATORIAL <b>Washington Nat. Cem.</b>
24. FUNERAL DIRECTOR <b>Robert Wilhelm Fun.</b>		ADDRESS <b>4308 Suitland Rd.</b>		25a. REC'D BY REGISTRAR DATE <b>NOV 25 1968</b>
				25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>



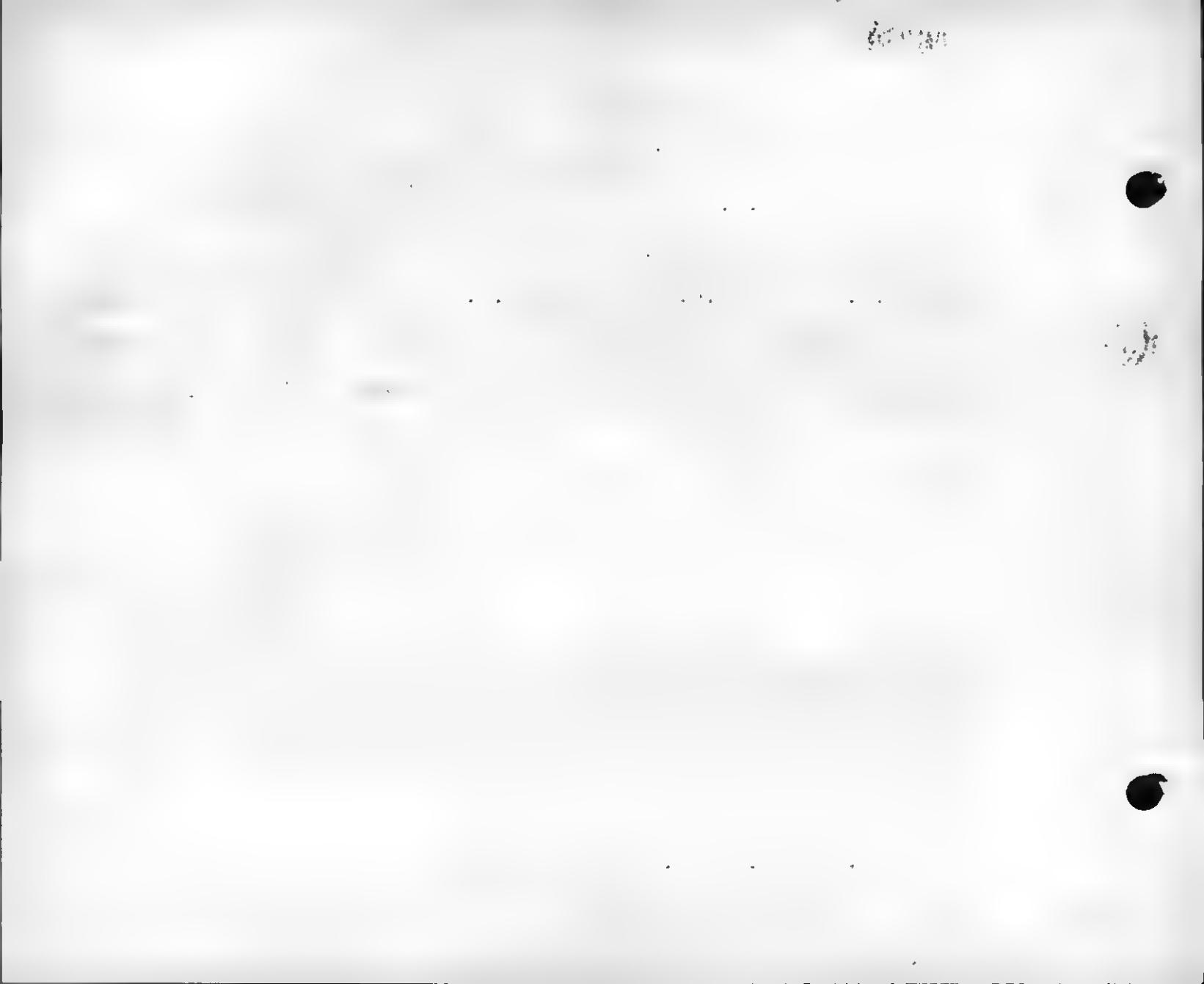
10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Part 4 may be signed by the hospital or attending physician.  
10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. In any event, within 72 hours after death, this certificate should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

**CERTIFICATE OF DEATH**

1 DECEASED NAME (Type or print)	First <b>ERIC LEE CALHOUN</b>	Middle <b>John</b>	Last <b>Calhoun</b>	2a. DATE OF DEATH Month <b>Nov</b>	Day <b>11</b>	Year <b>68</b>	2b. HOUR <b>10:30 AM</b>
3 SEX <b>M MALE</b>	4. RACE <b>N NEGRO</b>	5. DATE OF BIRTH <b>10 Nov 68</b>	6. AGE (In years last birthday) YRS. MONTHS DAYS	IF UNDER 1 YEAR HOURS MIN	IF UNDER 24 HRS.		
7a. BIRTHPLACE (State or foreign country) <b>MD</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9 COUNTY OF DEATH <b>PRINCE GEORGES</b>				
10 CITY OR TOWN OF DEATH <b>ANDREWS AFB</b>	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>MALCOLM GROW USAFHOSP</b>	12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>NA</b>	12b KIND OF BUSINESS OR INDUSTRY <b>NA</b>				
13a USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE <b>WASH D.C.</b>	13c CITY OR TOWN <b>D.C.</b>	13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e STREET AND NUMBER <b>3424 5th St SE Apt 11</b>				
14 FATHER'S NAME First <b>THEODORE</b>	Middle <b>CALHOUN</b>	15. MOTHER'S MAIDEN NAME First <b>VERA</b>	Middle <b>LOUISE</b>	Last <b>RAYNOR</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <b>NO</b>	16b. SOCIAL SECURITY NO. <b>NA</b>	17. INFORMANT <b>Father same as item # 13</b>	Address				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)							
PART I. DEATH WAS CAUSED BY.							
IMMEDIATE CAUSE (a) <b>RESPIRATORY DISTRESS SYNDROME</b>							
DUE TO, OR AS A CONSEQUENCE OF							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) <b>PREMATURE BIRTH</b>							
DUE TO, OR AS A CONSEQUENCE OF							
(c)							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>no</b>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY OFFICE BUILDING, ETC.)	21f. LOCATION Street or RFD No City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <b>10 Nov 68</b> , to <b>11 Nov 68</b> , that (I) (we) last saw the deceased alive on <b>11 Nov 68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>John A. Moore</b>	DEGREE ATTENDING PHYS.	<input type="checkbox"/> MED DIRECTOR	<input type="checkbox"/> STAFF PHYS	<input checked="" type="checkbox"/>	22c. DATE SIGNED <b>11 Nov 68</b>		
22d. PHYSICIAN'S <b>JOHN A. MOORE, CAPT, USAF, MC</b>	22e. ADDRESS <b>MALCOLM GROW USAFHOSP ANDREWS AFB</b>						
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Nov 14, 1968</b>	23b. DATE <b>Nov 14, 1968</b>	23c. NAME OF CEMETERY OR CREMATORIAL <b>MILLER Cemetery</b>	23d. LOCATION (City, County, State) <b>Jacksonville N.C.</b>				
24. FUNERAL DIRECTOR <b>JOHNSON &amp; Jenkins F.A. Inc.</b>	ADDRESS <b>4804 G.A. Ave NW WASH DC 20011</b>	25a. REG'D BY REGISTRAR <b>18 Nov 68</b>	25b. REGISTRAR'S SIGNATURE <b>Charles Johnson</b>				
VR A15 (4) 30M REV. 1/68							



MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
CERTIFICATE OF DEATH

**10 HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.  
 Page 4 may be retained by the hospital or attending physician.

**10 FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to a burial, cremation, or removal, and in any event, within 72 hours after death.

1 DECEASED NAME (Type or print)		First <b>Vito</b>	Middle	Last <b>Candore</b>	2a DATE OF DEATH Month <b>November</b>	Day <b>3</b>	Year <b>68</b>	2b HOUR <b>10:30</b>					
3 SEX <b>Male</b>		4 RACE <b>Cauc.</b>	S DATE OF BIRTH <b>09-27-04</b>	6. AGE (In years last birthday) <b>64 yrs</b>	IF UNDER 1 YEAR MONTHS <b>0</b>			IF UNDER 24 HRS HOURS <b>0</b>					
7a BIRTHPLACE (State or foreign country) <b>Italy</b>		7b. CIT ZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9 COUNTY OF DEATH <b>Prince Georges</b>									
10 CITY OR TOWN OF DEATH <b>Cheverly</b>		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Prince Georges Gen. Hosp.</b>		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Tile Setter</b>					12b. KIND OF BUSINESS OR INDUSTRY				
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <b>Md.</b>		13c. CITY OR TOWN <b>Prince Georges Seat Pleasant</b>	.3d INSIDE CITY LIMITS? <b>YES</b>	.3e STREET AND NUMBER <b>6902 A Street</b>									
14 FATHER'S NAME First <b>Frank</b>		Middle <b>Candore</b>	15 IS MOTHER'S MAIDEN NAME First <b>Angelina</b>	Middle	Last								
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <b>No</b>		16b SOCIAL SECURITY NO	17 INFORMANT <b>Oceola R. Candore</b>	Address <b>6902 A St. Seat Pleasant</b>									
18 CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Generalized peritonitis, with localized abscesses,</b> DUE TO OR AS A CONSEQUENCE OF <b>pelvic and left subdiaphragmatic.</b> Conditions, if any, wh ch gave rise to immediate cause (a), stating the underlying cause (b) <b>Small bowel, cutaneous fistula.</b> DUE TO, OR AS A CONSEQUENCE OF (c)											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(c) <b>578</b>													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? <b>YES</b>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>Yes</b>								
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)										
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)	21f LOCATION Street or RFD No	City or Town	County				State				
22a. I certify that (I) <b>(checkboxed)</b> attended the deceased from <b>Sept. 28, 1968</b> , to <b>Nov. 3, 1968</b> , that (I) <b>(x)</b> last saw the deceased alive on <b>Nov. 3, 1968</b> , and that in (my) <b>(x)</b> opinion death occurred on the date and hour and from the causes stated above, (I) <b>(x)</b> did <b>(checkboxed)</b> view the body after death.													
22b. SIGNATURE <i>Saul Schwartzbach, M.D.</i>		22c DATE SIGNED <b>Nov. 3, 1968</b>											
22d. PHYSICIAN'S NAME (Type) <b>Saul Schwartzbach, M. D.</b>		22e. ADDRESS <b>106 Irving St., Suite 405, Washington, D.C.</b>											
23a BURIAL, CREMATION REMOVAL (Specify) <b>Burial</b>		23b DATE <b>11-7-68</b>	23c NAME OF CEMETERY OR CREMATORIAL <b>Resurrection Cemetery</b>	23d LOCATION (City or Town) <b>Clinton</b>	(County) <b>Pr. Geo.</b>	(State) <b>Md.</b>							
24. FUNERAL DIRECTOR <b>Wilhelm Funeral Home 4308 Suitland Rd. S. E.</b>		ADDRESS	25a. REC'D BY REGISTRAR <b>NOV 6 1968</b>	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>									
VR AIS 144 45M - 1 69		DATE											

120

42

120

120

120

120

120

## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## CERTIFICATE OF DEATH

1631

**10 HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

**10 FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician or attending physician, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers from pages 1 and 2, and attach page 3 to the State Dept. of Health prior to burial, cremation, or removal, until any event, within 72 hours of death.

1 DECEASED NAME (Type or print)	First <i>Francesca -</i>	Middle <i>Caruso</i>	Last <i>Caruso</i>	2a. DATE OF DEATH Month 11	Day 8	Year 1968	2b. HOUR 12 <sup>00</sup> P.M.	
3. SEX <i>Female</i>	4. RACE <i>Car</i>	S. DATE OF BIRTH <i>6-6-1893</i>	6 AGE (In years last birthday) <i>75 yrs.</i>	7. IF UNDER 24 HRS MONTHS DAYS		8. IF UNDER 24 HRS HOURS MIN.		
7a. BIRTHPLACE (State or foreign country) <i>Italy</i>	7b. CITIZEN OF WHAT COUNTRY? <i>ITA/IV</i>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH <i>Prince George</i>					
10 CITY OR TOWN OF DEATH <i>Greenbelt</i>	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Greenbelt Convalescent Center</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>housewife</i>	12b. KIND OF BUSINESS OR INDUSTRY				
13a. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) STATE <i>Maryland</i>	13b. COUNTY <i>Prince George</i>	13c. CITY OR TOWN <i>Gaithersburg</i>	13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	13e. STREET AND NUMBER <i>15612 Jones Lane</i>				
14. FATHER'S NAME First <i>Joseph -</i>	Middle <i>Demisa</i>	Last <i>Giacchini Copoli</i>	15. MOTHER'S MAIDEN NAME First <i>Giacchini Copoli</i>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <i>No</i>	16b. SOCIAL SECURITY NO	17. INFORMANT <i>Mrs. VINCENTA J MAG</i>	Address <i>WASHINGTON DC</i>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Myocardial Failure</i>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>12 hr</i>				
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause <i>Arteriosclerosis Coronary Artery Disease</i>				15 yr				
DUE TO, OR AS A CONSEQUENCE OF (b) <i>Generalized Arteriosclerosis</i>				15 yr				
DUE TO, OR AS A CONSEQUENCE OF (c) <i>Generalized Arteriosclerosis</i>								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)								
19a. MEDICAL CERTIFICATION		19b. DATE OF OPERATION	19c. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)	21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <i>Feb. 1968</i> to <i>Nov. 1968</i> , that (I) (we) lost saw the deceased alive on <i>8 Nov. 1968</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE <i>Wm A Wimsatt MD</i>		22c. DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>	DATE SIGNED <i>8 Nov. 68</i>					
22d. PHYSICIAN'S NAME (Type) <i>Wm A Wimsatt</i>		22e. ADDRESS <i>3415 Hamilton St Hyattsville, Md.</i>						
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>Nov 11, 1968</i>	23c. NAME OF CEMETERY OR CREMATORIUM <i>Ft Lincoln Cemetery</i>	23d. LOCATION (City or Town) <i>Colmar Manor Pro Geo Md.</i>		(County) (State)		
24. FUNERAL DIRECTOR <i>F. Gasch's Sons</i>		ADDRESS <i>Hyattsville, Md.</i>	25a. REC'D BY REGISTRAR DATE <i>NOV 12 1968</i>	25b. REGISTRAR'S SIGNATURE <i>Charles Judy</i>				

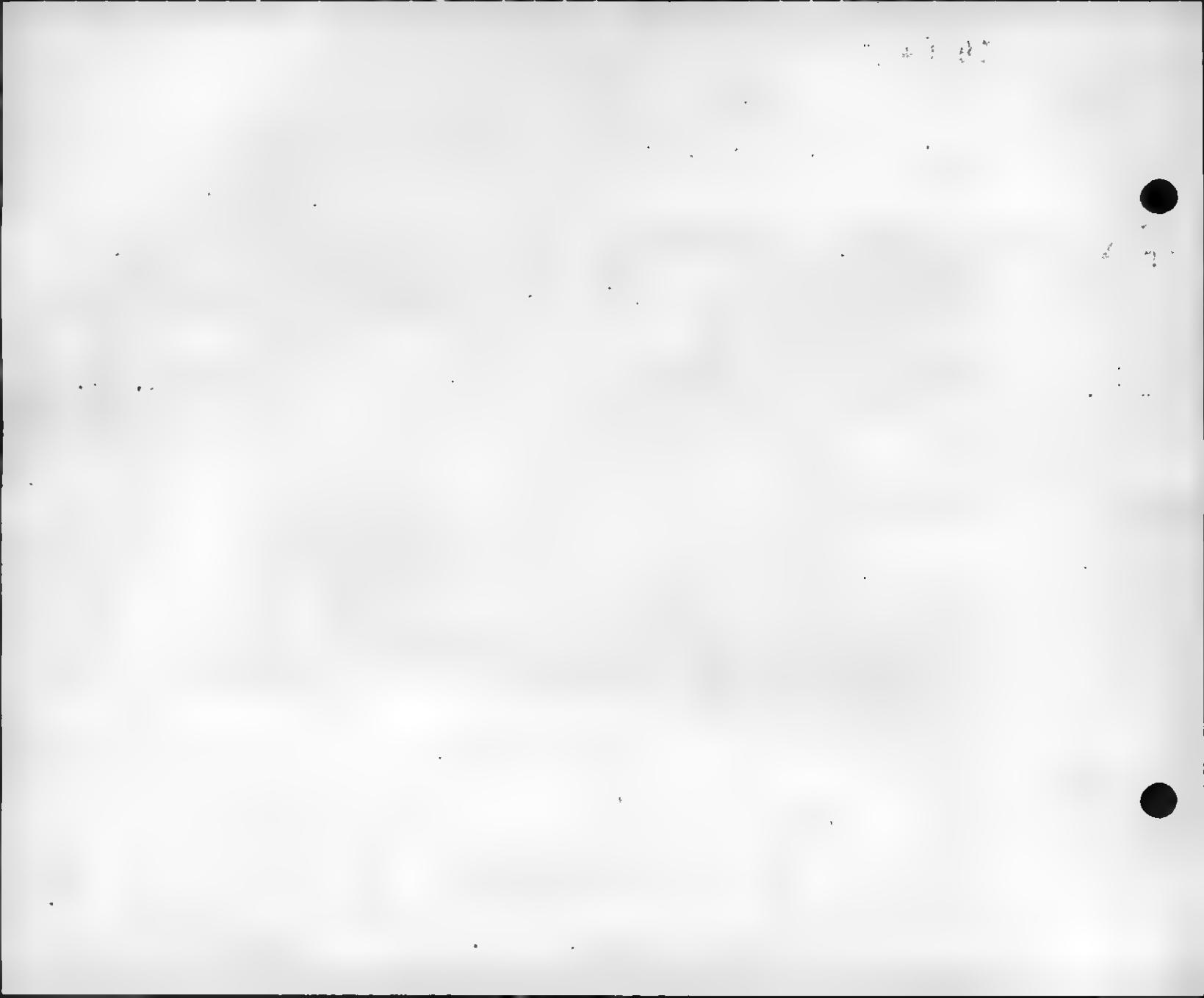


FOR STATE  
HEALTH DEPT.

61  
1  
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Five pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH												16313							
1. DECEASED NAME (Type or Print)			First	Middle	Last	2a. DATE KNOWN OF ESTI- DEATH MADE			Month	Day	Year	2b. HOUR							
			Katharine	Cobb	Chappell				Nov 26, 1968			1 P.M.							
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years less birthday)	IF UNDER 1 YEAR	\$ UNDER 24 HRS	2c. DATE PRONOUNCED DEAD			Month	Day	Year	2d. HOUR							
female	white	Nov 26, 1892	76 yrs	MONTHS	DAYS	HOURS	MIN	11 26 1968			1:30M								
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		9. COUNTY OF DEATH		10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL OR INSTITUTION (If not a hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY			
Delaware		U.S.A.		WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		Prince George's		Beltsville				Eleven Cedars Nursing home		Clerk		P.O. Dep't			
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER				14. FATHER'S NAME		First		Middle	Last	15. MOTHER'S MAIDEN NAME	
Md		Prince George's		Riverdale		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		4717 Riverdale Road				Winfield S. Byron		First		Letitia Johnson			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		(If yes give war or dates of service)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS				18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
no						Katharine Patrick		Riverdale, Md.						IMMEDIATE CAUSE (a)		Never			
4129		Conditions, injury, which gave rise to immediate cause (a), stating the underlying cause last		(b)		Heart failure								DUE TO, OR AS A CONSEQUENCE OF		over 2 yrs			
				(c)		ASHD													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) CVH - congestive heart failure												20. AUTOPSY?							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?														YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
MEDICAL CERTIFICATION																			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M.		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)															
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No.		City or Town		County		State									
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>												CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ADDRESS (Street, city, town, or county)							
ACTUAL SIGNATURE		John Kehoe		M.D.								22b. DATE SIGNED		11-26-68					
EXAMINER'S NAME (Type)		J. K. KEHOE, M.D.																	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL		23d. LOCATION (City or Town)		(County)		(State)									
Burial		Nov 29, 1968		Ft Lincoln Cemetery		Colmar Manor		Panor Pro Geo		Md.									
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REG STRAR		25b. REG STRAR'S SIGNATURE													
F. Gasch's Sons		Hyattsville, Md.		DEC 2 1968		Charles J. ...													



MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
**CERTIFICATE OF DEATH**

16303 16303

**10 HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.  
**Page 4 may be retained by the hospital or attending physician.**  
**11 TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in and completely filed by the funeral director, page 3 should be detached for use as the burial-transit permit. This certificate may be removed carbon papers pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print)		First <b>Estelle</b>	Middle <b>Claggett</b>	Lost	2a. DATE OF DEATH Month <b>Nov.</b>	Day <b>20,</b>	Year <b>1968</b>	2b. HOUR <b>2:30 PM</b>
3 SEX <b>Female</b>	4. RACE <b>Negro</b>	5. DATE OF BIRTH <b>Jan. 1, 1891</b>		6. AGE (In years last birthday) <b>77</b>	IF UNDER 1 YEAR MONTHS <b>YRS.</b>		IF UNDER 24 HRS MONTHS DAYS HOURS MIN	
7a BIRTHPLACE (State or foreign country) <b>Maryland</b>	7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <b>XX</b> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Prince George's</b>				
10 CITY OR TOWN OF DEATH <b>Cheverly</b>	11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital (give street address) <b>Prince Geo. Gen'l Hospital</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>Retired</b>		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution on admission) <b>Maryland</b>	13b. COUNTY <b>Prince George's</b>	13c. CITY OR TOWN <b>Chapel Oaks</b>	13d. INSIDE CITY OR TSP YES <input type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER <b>5702 Nome Street</b>				
14 FATHER'S NAME <b>John W. Clark</b>	First Middle Last	15 MOTHER'S MAIDEN NAME <b>Harriett Butler</b>		Middle	Last			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown)	(If yes give war or dates of service)	16b. SOCIAL SECURITY NO	17 INFORMANT <b>Sister</b>	Address <b>Mrs. Teresa Briscoe-5702 Nome Street</b>				
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>RESPIRATORY FAILURE</b>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
4000 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause <b>lost</b>								
(b) <b>SUBARACHNOID HAEMORRHAGE</b>								
DUE TO, OR AS A CONSEQUENCE OF (c) <b>HYPERTENSION.</b>								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
				YES <input type="checkbox"/> NO <b>XX</b>				
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or RFD No.	City or Town	County	State		
22a. I certify that <b>XX</b> (this hospital) attended the deceased from <b>Nov. 14, 1968</b> , to <b>Nov. 20, 1968</b> , that <b>XX</b> (we) last saw the deceased alive on <b>Nov. 20, 1968</b> , and that <b>XX</b> (our) opinion death occurred on the date and hour and from the causes stated above. <b>XX</b> (we) did not view the body after death.								
22b. SIGNATURE <i>Dewitt</i>		DEGREE ATTENDING PHYS	<input type="checkbox"/>	MED DIRECTOR	<input type="checkbox"/>	STAFF PHYS	<b>XX</b>	
22c. DATE SIGNED <b>Nov. 21, 1968</b>								
22d. PHYSICIAN'S NAME (Type) <b>P. C. Xavier, M. D.</b>		22e. ADDRESS <b>Prince Geo. Gen'l Hospital, Cheverly, Md.</b>						
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>11/23/68</b>	23c. NAME OF CEMETERY OR CREMATORIUM <b>Mt. Olivet Cemetery</b>	23d. LOCATION (City or Town) <b>Washington, D.C.</b>		(County)	(State)	
24. FUNERAL DIRECTOR <b>John J. Stewart</b>		ADDRESS <b>Funeral Home-4001 Benning Road N.E.</b>		25a. RECD BY REGISTRAR <b>DATE 11/21/68</b>	25b. REGISTRAR'S SIGNATURE <b>John J. Stewart</b>			



MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

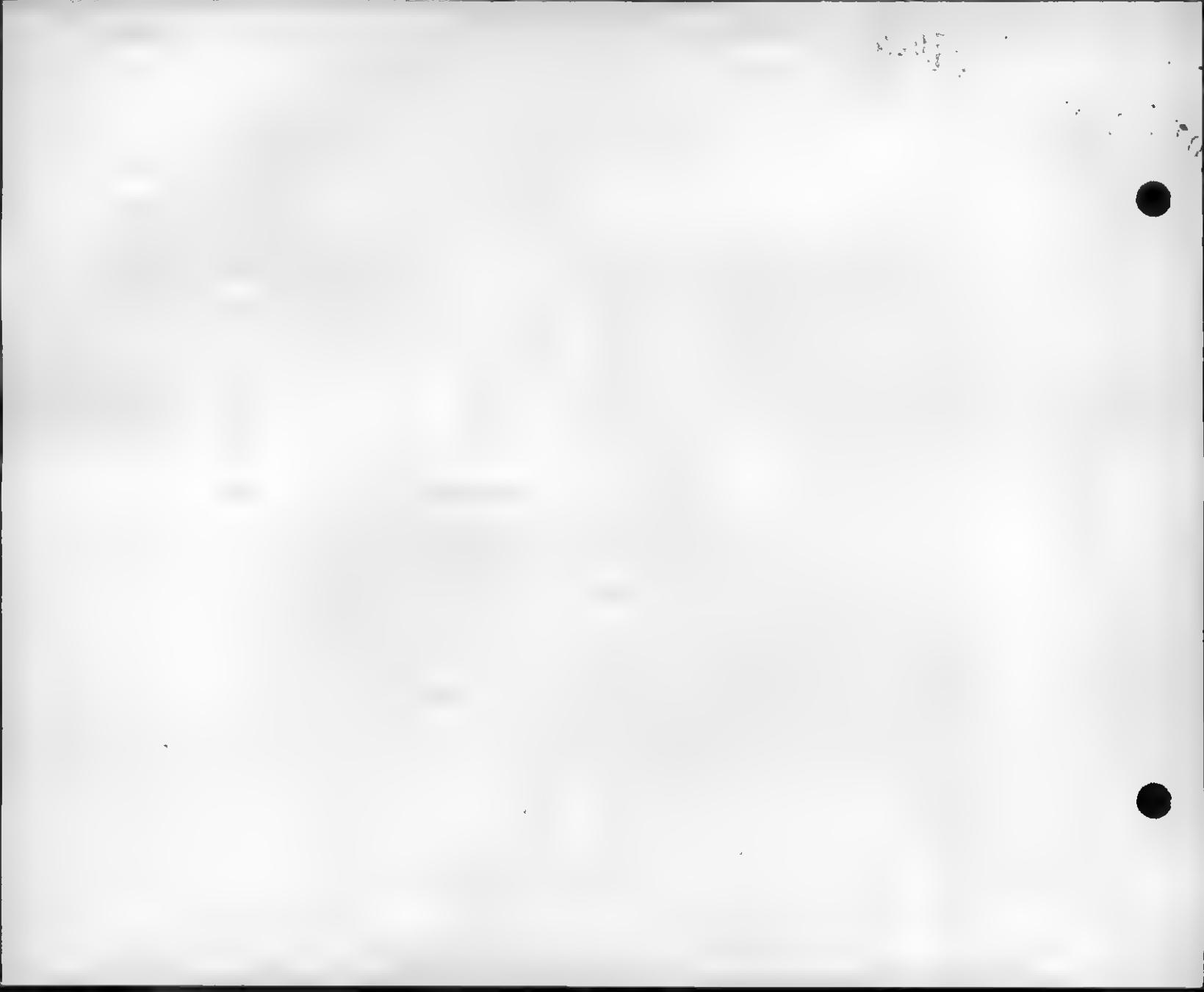
16306 16320

**CERTIFICATE OF DEATH**

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician or attending physician or director, page 3 should be detached for use on the burial permit. Then please remove carbon papers. Please sign and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print)				First	Middle	Last	2a. DATE OF DEATH Month Day Year	2b. HOUR AM PM
<i>Edna PEARL CLEMENTS</i>						NOV. 27 1968	7:05 PM	
3. SEX <i>F.</i>		4. RACE <i>White</i>		5. DATE OF BIRTH <i>11-12-91</i>		6. AGE (In years last birthday) <i>77 yrs.</i>	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (State or foreign country) <i>Md.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Prince George's</i>	10. CITY OR TOWN OF DEATH <i>Baltimore</i>	
11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Prince George's General</i>		12a. US-JAI OCCUPATION (Kind of work done during most of working life, even if retired) <i>Housewife</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Home</i>		13a. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) <i>Md.</i>	13b. CITY OR TOWN <i>P.G.A. Edgewater</i>	
14. FATHER'S NAME <i>WILLIAM MEINBURG</i>		15. MOTHER'S MAIDEN NAME <i>UNKNOWN</i>		16b. SOCIAL SECURITY NO. <i>—</i>		17. INFORMANT <i>Louis W Litz</i>	Address <i>9100 Armistice Rd., Upper Marlboro, Md.</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Hepatic coma</i>						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
1538 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause <i>Metastatic carcinoma of the liver</i>		DUE TO, OR AS A CONSEQUENCE OF (b) <i>Metastatic carcinoma of the liver</i>		DUE TO, OR AS A CONSEQUENCE OF (c) <i>Adenocarcinoma of colon</i>				
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) <i>ASHD</i>								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town	County State	
22a. I certify that (I) (this hospital) attended the deceased from <i>3/5</i> , 19 <i>68</i> , to <i>11/27</i> , 19 <i>68</i> , that (I) (we) last saw the deceased alive on <i>11/27</i> , 19 <i>68</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE <i>MD</i>		22c. DEGREE <i>ATTENDING PHYS</i>		22d. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22e. DATE SIGNED <i>11-27-68</i>		
22e. PHYSICIAN'S NAME (Type) <i>DR. DAVID ANDERS</i>		22f. ADDRESS <i>3308 Dodge Park Rd, Landover Md.</i>						
23a. BURIAL, CREMATION REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>Nov 30, 1968</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Cedar Hill</i>		23d. LOCATION (City or Town) <i>Landover Md.</i>		
24. FUNERAL DIRECTOR <i>Robert E. Wedderburn</i>		ADDRESS <i>45252 S. Santon Rd., Landover Md.</i>		25a. REC'D. BY REGISTRAR DATE <i>DEC 3 1968</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		



MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.  
**Page 4 may be retained by the hospital or attending physician.**

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1, 2, and 3 should be filed with the State Dept. of Health prior to a burial, cremation, or removal, and in any event, within 72 hours after death.

1 DECEASED NAME (Type or print)				First <b>William</b>	Middle <b>Heman</b>	Last <b>Clements Sr</b>	2a. DATE OF DEATH Month <b>Nov 3, 1968</b>	2b. HOUR <b>12:40 PM</b>
3 SEX <b>male</b>		4. RACE <b>white</b>		5. DATE OF BIRTH <b>July 20, 1907</b>		6. AGE (in years at birthday) <b>81</b>	F. UNDER 1 YEAR MONTHS <b>YRS</b>	I. UNDER 24 HRS HOURS <b>MIN</b>
7a. BIRTHPLACE (State or foreign country) <b>Washington</b>		7b. CITIZEN OF WHAT COUNTRY? <b>D C U S A</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Prince George's</b>		
10. CITY OR TOWN OF DEATH <b>Hyattsville</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>6001 35th ave</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>General Practice</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Physician</b>	
13a. USUAL RESIDENCE (Where deceased lived, if institution- Residence before admission) STATE <b>Md</b>		13b. COUNTY <b>Pro Geo</b>		13c. CITY OR TOWN <b>Hyattsville</b>		13d. INSIDE CITY LIMITS? <b>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></b>	13e. STREET AND NUMBER <b>6001 35th ave</b>	
14. FATHER'S NAME First <b>Lyman J Clements</b>				15. MOTHER'S MAIDEN NAME First <b>Hariette C Battles</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <b>Yes</b>		16b. SOCIAL SECURITY NO <b>220 44 2705</b>		17. INFORMANT <b>W H Clements Jr</b>		Address <b>Cheverly, Md.</b>		
<p>18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))</p> <p>PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>RUPTURED ANEURYSM OF LEFT VENTRICLE</b> FEW MIN 4109 DUE TO, OR AS A CONSEQUENCE OF (b) <b>ACUTE MYOCARDIAL INFARCTION</b> 28 DAYS Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.</p> <p>DUE TO, OR AS A CONSEQUENCE OF (c) <b>THROMBOSIS OF LEFT CORONARY ARTERY</b> 28 DAYS</p> <p>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(c)</p> <p>4201</p>								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? <b>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></b>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>YES</b>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.	City or Town		County	State
22a. I certify that (I) (this hospital) attended the deceased from <b>OCT 27, 1968</b> , to <b>NOV. 3, 1968</b> , that (I) (we) last saw the deceased alive on <b>NOV. 2 1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE <i>J. E. Bowman, M.D.</i>		ATTENDING DEGREE PHYS.		<input checked="" type="checkbox"/> MED. DIRECTOR	<input type="checkbox"/> STAFF PHYS.		22c. DATE SIGNED <b>NOV. 3, 1968</b>	
22d. PHYSICIAN'S NAME (Type) <b>J. E. BOWMAN, M.D.</b>		22e. ADDRESS <b>4021-18TH ST., N.E.</b>						
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>Nov 7, 1968</b>		23c. NAME OF CEMETERY OR CREMATORIAL <b>Ft Lincoln Cemetery</b>		23d. LOCATION (City or Town) (County) <b>Colmar Manor Pro Geo Md.</b>		
24. FUNERAL DIRECTOR <b>F. Gasch's Sons</b>		ADDRESS <b>Hyattsville, Md.</b>		25a. REC'D BY REGISTRAR DATE <b>NOV 8 1968</b>		25b. REGISTRAR'S SIGNATURE <i>J. Charles Judge</i>		



FOR STATE  
HEALTH DEPT.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1632

1 DECEASED NAME (Type or Print)		First	Middle	Lost	20 DATE KNOWN OF ESTI. DEATH MATED	Month	Day	Year	2b HOUR		
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (In years last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS						
Male	White	7-5-1944	24 YRS	MONTHS	DAYS	HOURS	MIN				
7a BIRTHPLACE (State or foreign country)		7b. C. TIZEN OF WHAT COUNTRY?	8.	MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		2c DATE PRONONC'D DEAD Month Day Year			
Washington,		D. C. U.S.A.						11 COUNTY OF DEATH	2d HOUR		
9 COUNTY OF DEATH			Prince George's Md.								
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b KIND OF BUSINESS OR INDUSTRY		
Cheverly			Prince George Hospital			Policeman					
13a USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) STATE			13c CITY OR TOWN			13d INSIDE CITY LIMITS?			13e STREET AND NUMBER		
Maryland			Prince George's Hyattsville			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			2716 73rd. Place		
14. FATHER'S NAME			First	Middle	Lost	15. MOTHER'S MAIDEN NAME			First	Middle	Lost
William Clements						Irane Phillips					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b SOCIAL SECURITY NO (If yes give war or dates of service)			17 INFORMANT			ADDRESS		
Yes			unknown			Blanche R. Clements 2118 - 74th Ave.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY											
IMMEDIATE CAUSE (a) Multiple gunshot wounds of head and chest APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF											
(c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
981X											
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY?		
									YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
MEDICAL CERTIFICATION											
21a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH WHILE AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21b TIME OF INJURY Month, Day, Year HOUR A.M. 2:30pm 11-30- 1968			21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
						Shot by assailant.					
21d. LOCATION Street or R.F.D. No.						City or Town			County State		
7000 block Greig Street, Seat Pleasant, Prince George Co., Md.											
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE						CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22b. DATE SIGNED		
EXAMINER'S NAME (Type)						M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			12-1-68		
John Kehoe MD Riverdale, Md.						DEPUTY MEDICAL EXAMINER <input type="checkbox"/>					
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION (City or Town) (County) (State)		
Burial			12-4-68			Ft. Lincoln			Bladensburg Pr. Geo. Md.		
24. FUNERAL DIRECTOR			ADDRESS			25a. REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE		
Wilhelm Funeral Home 4308 Suitland Rd. S. E.						DEC 9 1968			Charles Judge		



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 1a. If you file it later than 24 hours, forward it to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1630

16323

1. DECEASED NAME (Type or Print)		First	Middle	Last	2a. DATE KNOWN OF ESTI- DEATH MATED	Month	Day	Year	2b. HOUR AM
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (in years last birthday), YEARS	7. IF UNDER 1 YEAR MONTHS DAYS	8. IF UNDER 24 HRS HOURS MIN	11	22	1968	2:00
M	W	13 Mar.	1907			11	22	1968	2d. HOUR 3:09 a.m.
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	9. COUNTY OF DEATH	Prince George			
VIRGINIA		USA		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY	
Cheverly		Prince George Hosp.			ANIMAL HELPER			DEPT OF AGRICULTURE	
13a. USUAL RESIDENCE (Where deceased resided, if institution admission) STATE		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER			
Md.		Ann Arundel		Laurel		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		3410 Suderville St.	
14. FATHER'S NAME		First	Middle	Last	15. MOTHER'S MAIDEN NAME	First	Middle	Last	
NATHAN COAPLIN					ELIZABETH BOYLE				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO (If yes give war or dates of service)		17. INFORMANT		ADDRESS			
{Yes, no, or unknown}		579-22-1487		HELEN COAPLIN		ABOVE			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									
PART I. DEATH WAS CAUSED BY.									
IMMEDIATE CAUSE (a) Heart failure APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Min.									
DUE TO, OR AS A CONSEQUENCE OF									
Conditions, if any, which gave rise to immediate cause (a) { (b) Arteriosclerotic heart disease Unknown									
stating the underlying cause last. (c)									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?					
4/10				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?					
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No City or Town County State					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE		John Kehoe, M.D., Riverdale		CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		22b. DATE SIGNED			
EXAMINER'S NAME (Type)						11-28-68			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE 11-25-68		23c. NAME OF CEMETERY, OR CREMATORIAL ADDRESS		23d. LOCATION (City or Town) Colmar Manor Md.			
24. FUNERAL DIRECTOR						25a. REC'D BY REGISTRAR DATE NOV 26 1968			
Danaelian Funeral Home Laurel						25b. REGISTRAR'S SIGNATURE Charles Judge			



MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

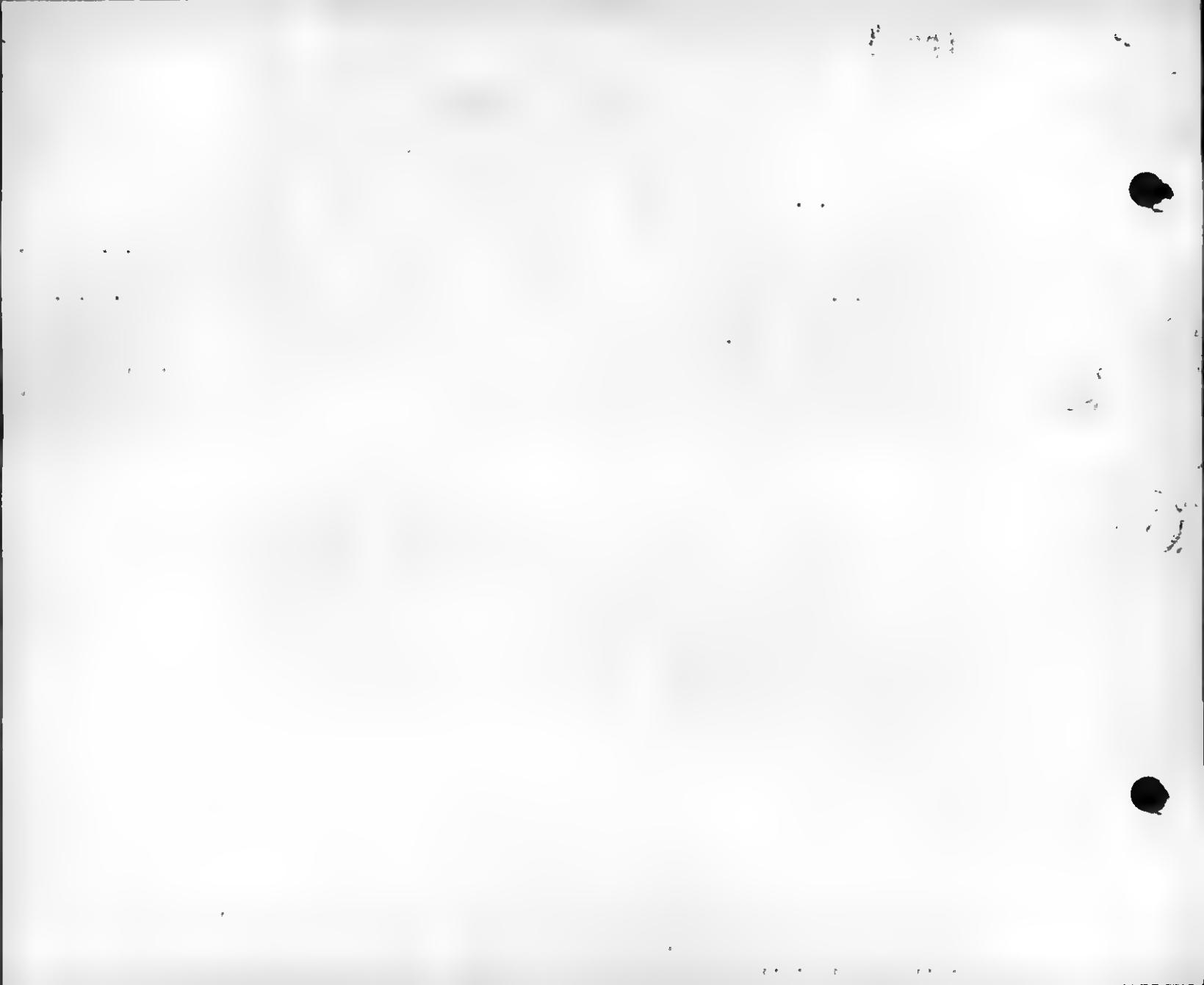
16310

CERTIFICATE OF DEATH

16320

**10 HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.  
**Page 4** may be retained by the hospital or attending physician.  
**10 FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician, and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. In case remove carbon papers. Pages 1, 2, and 3 should be filed with the State Dept. of Health or a burial, cremation, or removal, and in any event, within 72 hours after death.

1 DECEASED NAME (Type or print)		First <b>JESSIE</b>	Middle <b>LEE</b>	Last <b>COLLINS</b>	2a. DATE OF DEATH Month <b>Nov</b>	Year <b>1968</b>	2b. HOUR <b>8:05 A.M.</b>	
3 SEX <b>female</b>	4. RACE <b>Caucasian</b>	5. DATE OF BIRTH <b>9-16-1882</b>			6. AGE (in years last birthday) <b>86</b>	IF UNDER 1 YEAR MONTHS <b>YRS.</b>	IF UNDER 24 HRS. HOURS MIN	
7a. BIRTHPLACE (State or foreign country) <b>Washington, D.C.</b>	7b. CITIZEN OF WHAT COUNTRY? <b>United States</b>	B MARRIED <input checked="" type="checkbox"/>	NEVER MARRIED <input type="checkbox"/>	WIDOWED <input checked="" type="checkbox"/>	DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH <b>Prince Georges</b>		
10 CITY OR TOWN OF DEATH <b>Hyattsville</b>	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>carroll Manor Nursing Home</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Navy Dept.</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>U.S. Gov't.</b>	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>D.C.</b>	13b. COUNTY <b>✓ Washington</b>	13c. CITY OR TOWN <b>Washington</b>	13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES	13e. STREET AND NUMBER <b>4124 Fessenden St. N.W.</b>				
14 FATHER'S NAME First <b>William</b>	Middle <b>H.</b>	Last <b>Hunter</b>	15 MOTHER'S MAIDEN NAME First <b>Catherine</b>	Middle	Last <b>Caldwell</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <b>yes</b>	16b. SOCIAL SECURITY NO. <b>WW I</b>	17 INFORMANT <b>577-12-1079-D</b>	Wash. Address D.C., 20016 <b>Mrs. Paul R. Wilson, Neice, 5607 Marengo Rd.</b>					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>4129</b> Due to, or as a consequence of Conditions, if any, which gave rise to named immediate cause (a), stating the underlying cause <b>last. 4221</b> (b) Due to, or as a consequence of (c)								
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Disease</b> <b>Atherosclerotic Cardiovascular, 4 years</b> <b>Generalized Atherosclerosis</b> <b>4 years</b>								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>Osteoarthritis - Spine and hips.</b>								
21a. MEDICAL CERTIFICATION		19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. <b>19</b>	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
		21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (At HOME, FARM, STREET, FACTORY OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No	City or Town	County	State	
		22a. I certify that (I) (this hospital) attended the deceased from <b>Nov. 9, 1968</b> , to <b>Nov. 29, 1968</b> , that (I) (we) last saw the deceased alive on <b>Nov. 27, 1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
		22b. SIGNATURE <b>Francis P. Hannan MD</b>						
		22c. PHYSICIAN'S NAME (Type)	DEGREE <b>MD</b>	ATTENDING PHYS	<input checked="" type="checkbox"/> MED DIRECTOR	<input type="checkbox"/> STAFF PHYS	22c. DATE SIGNED <b>Nov. 29, 1968</b>	
		22e. ADDRESS <b>FRANCIS P. HANNAN 1511-17 ST. N.W. WASH. D.C.</b>						
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>12-4-1968</b>	23c. NAME OF CEMETERY OR CREMATORIAL <b>Arlington National Cemetery</b>	23d. LOCATION (City or Town) <b>Arlington, Virginia</b>	(County)	(State)		
24. FUNERAL DIRECTOR <b>Joseph Gawler's Sons, Inc., 5130 Wisc. Ave.</b>		ADDRESS <b>N.W., Wash., D.C., 20016</b>	25a. RECD BY REGISTRAR <b>DEC 5</b>	25b. REGISTRAR'S SIGNATURE <b>Charles Young</b>	DATE <b>1968</b>			



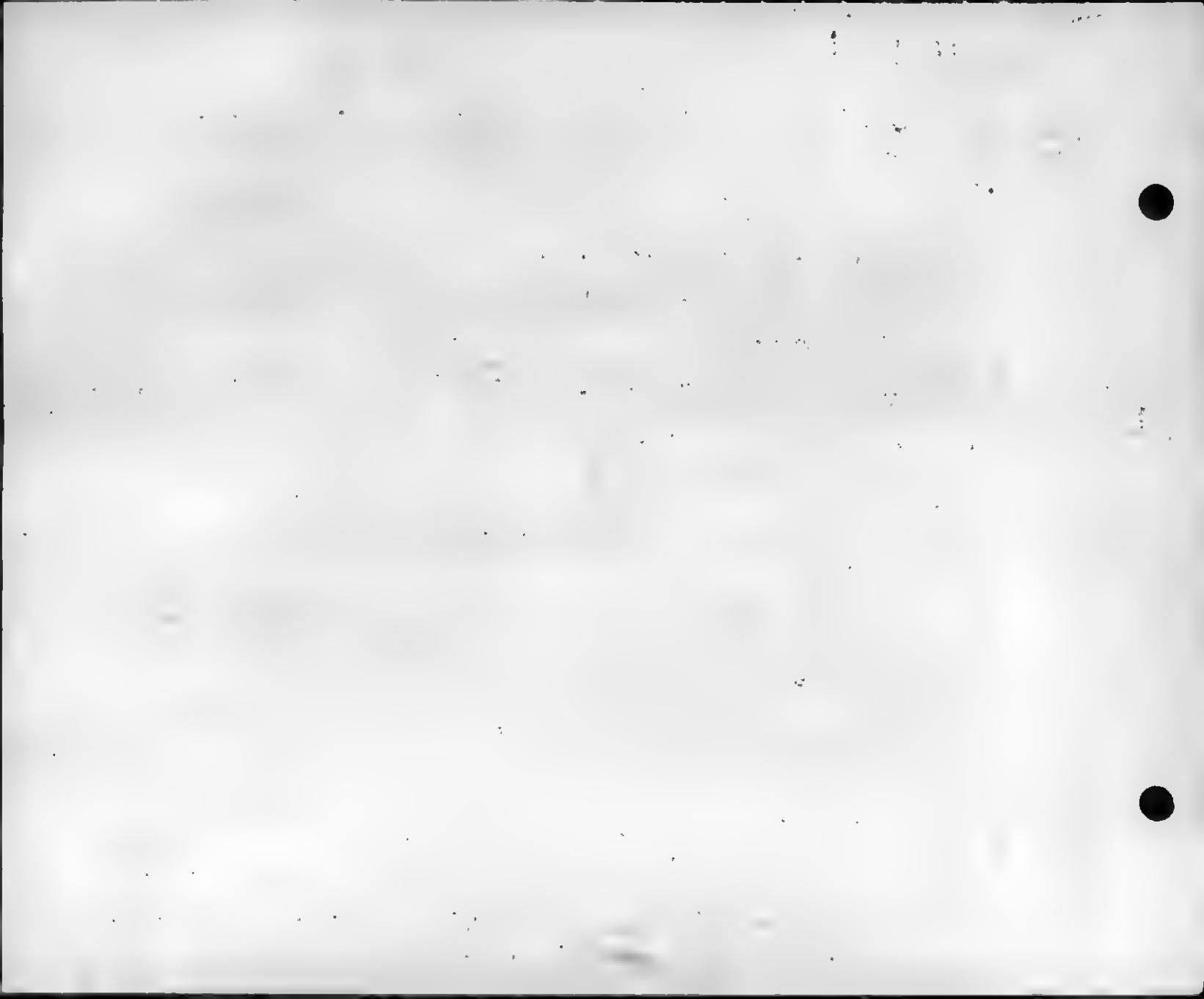
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
**CERTIFICATE OF DEATH**

16320

**10 HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.  
**10 FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 DECEASED NAME (Type or print)		First <i>William</i>	Middle <i>G.</i>	Last <i>Collins</i>	2a DATE OF DEATH Month <i>Nov</i>	Day <i>13, 1968</i>	Year <i>1968</i>	2b HOUR <i>6 A M</i>
3 SEX <i>male</i>	4 RACE <i>white</i>	5. DATE OF BIRTH <i>Sept 14, 1881</i>			6 AGE (in years last birthday) <i>87</i>	F UNDER 1 YEAR MONTHS <i>0</i>	IF UNDER 24 HRS HOURS <i>0</i>	MIN <i>0</i>
7a BIRTHPLACE (State or foreign country) <i>Md</i>	7b. CITIZEN OF WHAT COUNTRY? <i>U S A</i>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH <i>Prince George's</i>			Md
10 CITY OR TOWN OF DEATH <i>Beltsville, Md.</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>4916 Harford ave</i>			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>Builder</i>			12b KIND OF BUSINESS OR INDUSTRY <i>Self employed</i>
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Md</i>		13c. CITY OR TOWN <i>Pro George's</i>		13d. INSIDE CITY LIMITS? <i>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></i>	13e STREET AND NUMBER <i>4916 Harford ave</i>			
14 FATHER'S NAME First <i>Thomas P Collins</i>		Middle <i></i>	Last <i></i>	15. MOTHER'S MAIDEN NAME First <i>Mary Linton</i>			Middle <i></i>	Last <i></i>
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <i>No</i>		16b. SOCIAL SECURITY NO <i>212 20 1342A</i>		17. INFORMANT <i>Rosetta G Collins</i>			Address <i>Beltsville, Md.</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cachexia</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) <i>Gastric Carcinomatosis</i> DUE TO, OR AS A CONSEQUENCE OF lost (c) <i>Carcinoma Prostata</i>								
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>5 days</i>								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>177x</i>								
19a. DATE OF OPERATION <i>177x</i>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> YES <input type="checkbox"/> CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING ETC.)		21f. LOCATION Street or R.F.D. No. <i></i>	City or Town <i></i>		County <i></i>	State <i></i>
22a. I certify that (I) (this hospital) attended the deceased from <i>Sept 14, 1938, to Nov 12, 1968</i> , that (I) (we) last saw the deceased alive on <i>11/10/68</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE <i>William J. Warren MD</i>		22c. DATE SIGNED <i>11/13/68</i>			DEGREE <input checked="" type="checkbox"/> ATTENDING PHYS.	MED DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	
22d. PHYSICIAN'S NAME (Type) <i>J M WARREN</i>		22e. ADDRESS <i>Lancaster and</i>						
23a. BURIAL, CREMAT.ON, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>Nov 16, 1968</i>	23c. NAME OF CEMETERY OR CREMATORIUM <i>Ft Lincoln Cemetery</i>			23d. LOCATION (City or Town) <i>Colmar Manor</i>	(County) <i>Pro Georges</i>	(State) <i>Md</i>
24 FUNERAL DIRECTOR <i>F. Gasch's Sons</i>		ADDRESS <i>Hyattsville, Md.</i>	25a. RECD BY REGISTRAR DATE <i>NOV 18 1968</i>			25b. REGISTRAR'S SIGNATURE <i>Charles J. Gasch</i>		



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

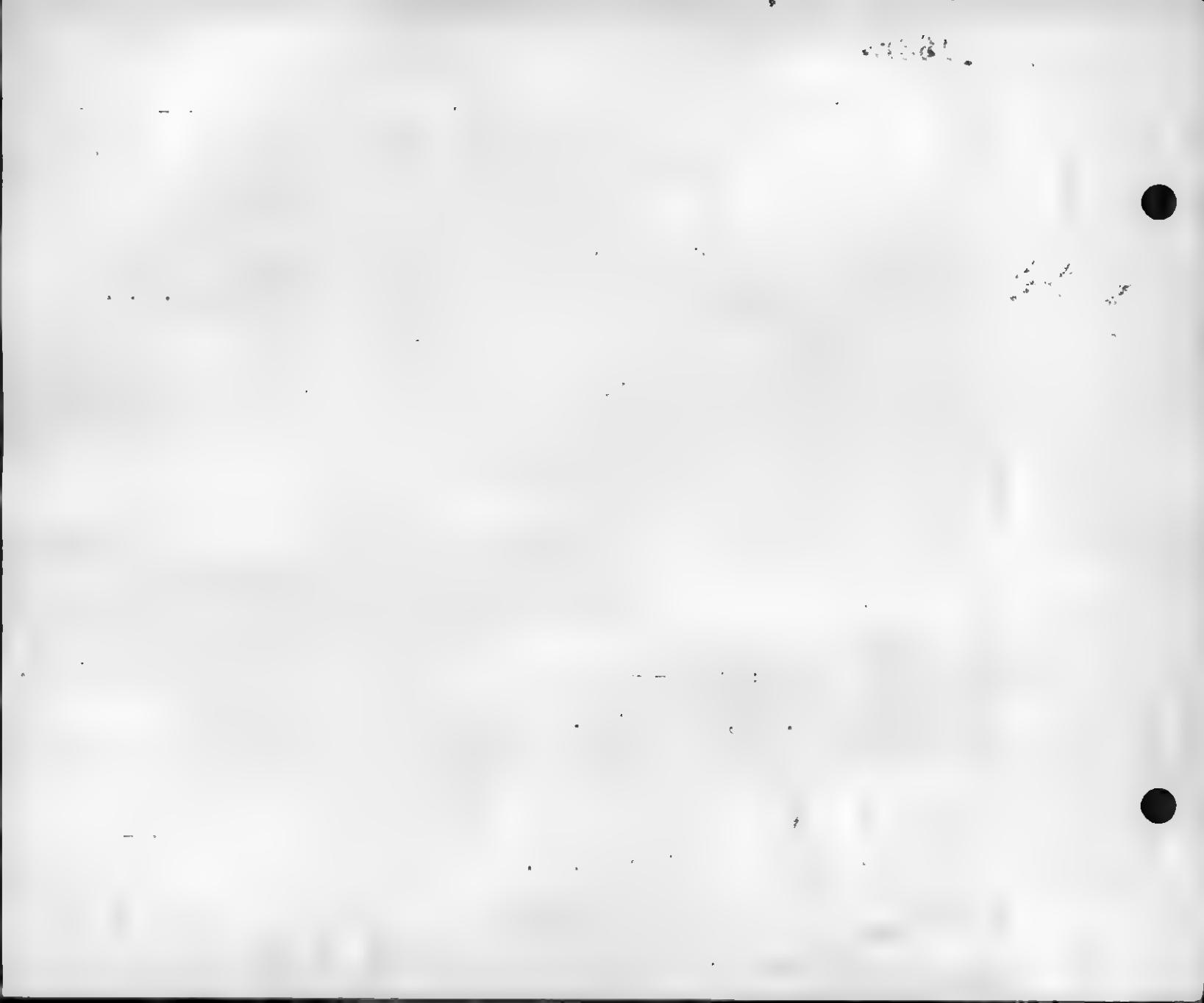
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

16312

1 DECEASED NAME (Type or Print)		First <b>Kinston</b>	Middle	Last <b>Cooper</b>	2a DATE KNOWN OF EST. DEATH MATED <input checked="" type="checkbox"/>	Month 11	Day 1-68	Year 1968	2b HOUR 17:23am M	
3 SEX Male	4. RACE Negro	5 DATE OF BIRTH 1-21-1937	6 AGE (In years last birthday) 31 yrs	IF UNDER 1 YEAR MONTHS 0	IF UNDER 24 HRS DAYS 0	HOURLS 0	MIN. 0		2d HOUR 2d HOUR	
7a BIRTHPLACE (State or foreign country) North Carolina		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH <b>Prince George's</b>	Md.	
10 CITY OR TOWN OF DEATH <b>Cheverly</b>			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Prince George Hospital</b>				12a USUAL OCCUPATION (Kind of work done during most of working life even if retired)			12b. KIND OF BUSINESS OR INDUSTRY
13a U.S.A. RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>District of Columbia</b>			13c CITY OR TOWN <b>Washington</b>		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER <b>142 Joliet St. N.E.</b>			
14 FATHER'S NAME First Not stated			Middle	Last	15 MOTHER'S MAIDEN NAME First Not stated			Middle	Last	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or Unknown) <b>No</b>		16b. SOCIAL SECURITY NO (If yes give name or dates of service) <b>None</b>		17 INFORMANT Unk.		ADDRESS <b>Pearline Cooper-142 Joliet Street, SW. #B</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <b>Hemorrhage and shock</b> DUE TO, OR AS A CONSEQUENCE OF <b>Evisceration</b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>2161</b>										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20 AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21c. MEDICAL CERTIFICATION PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. <b>7:20am 11-1- 1968</b>		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18) <b>Driver of cement truck involved in collision.</b>						
21d. INJURY OCCURRED WHILE AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) <b>Rt. 495, South of Rt. 4, Prince George County, Maryland</b>		21f. LOCATION Street or R.F.D. No City or Town County State						
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>										
ACTUAL SIGNATURE <i>J. Kehoe</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22b. DATE SIGNED <b>11-1-68</b>				
EXAMINER'S NAME (Type) <b>John Kehoe MD</b>		RIVERDALE, Md.		ADDRESS (Street, city, town, or county)						
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>11-5-68</b>		23c. NAME OF CEMETERY OR CREMATORIAL <b>Church Cemetery</b>		23d. LOCATION (City or Town) <b>Rocky Mount, North Carolina</b>		(County) (State)		
24. FUNERAL DIRECTOR <b>John T. Rhines Company Funeral Home</b>		ADDRESS <b>3015 12th Street, N. E.</b>		25a. RECD BY REGISTRAR <b>NOV 6 1968</b>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>				



FOR STATE  
HEALTH DEPT.

TO HOSPITAL: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

16313 1632

1 DECEASED NAME (Type or Print)		First	Middle	Lost	2a DATE KNOWN OF DEATH MATED	Month	Day	Year	2b HOUR	
		Richard	Francis	Coulter	Sr	11-8-68	.9 am	M		
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE IN YEARS (last birthday)	F UNDER 24 HRS						
Male	White	29 June 1905	63 yrs	MONTHS	DAYS	HOURS	MIN.			
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED	NEVER MARRIED	9. COUNTY OF DEATH	2c DATE PRONOUNCED DEAD			
Pennsylvania		U.S.A.		<input checked="" type="checkbox"/>	<input type="checkbox"/>	Prince George's	Month	Day	Year	
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b KIND OF BUSINESS OR INDUSTRY		
Cheverly		Prince George Hospital			Maintenance engineer			Hospital		
13a USUAL RESIDENCE (Where deceased lived, if institution residence before admission) STATE		13b. COUNTY		13c CITY OR TOWN	13d INSIDE CITY LIMITS?		13e STREET AND NUMBER			
Maryland		Prince George's		Bladensburg	YES <input checked="" type="checkbox"/>	NO <input type="checkbox"/>	5506 Newton Street # 3.			
14 FATHER'S NAME		First	Middle	Lost	15. MOTHER'S MAIDEN NAME		First	Middle	Lost	
		Thomas	Coulter				?			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO. (If yes give war or dates of service)		17. INFORMANT		ADDRESS				
no		170 05 8697		Richard F Coulter Jr		Adelphi, Md.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										
PART I. DEATH WAS CAUSED BY:										
IMMEDIATE CAUSE (a) Infarction of brain										
DUE TO, OR AS A CONSEQUENCE OF										
Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause (b) Occlusion of cerebral artery										
DUE TO, OR AS A CONSEQUENCE OF										
(c)										
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH										
4 days										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY?					
19c. MEDICAL CERTIFICATION					YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No.		City or Town	County	State		
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>										
ACTUAL SIGNATURE		John Kehoe			CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22b. DATE SIGNED 11-11-68			
EXAMINER'S NAME (Type)		John Kehoe MD Riverdale, Md.			ADDRESS (Street, city, town, or county)					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE Nov 13, 1968		23c. NAME OF CEMETERY OR CREMATORIUM George Washington cemetery		23d. LOCATION (City or Town) Hyattsville		(County) Pro Geo Md.	(State)	
24. FUNERAL DIRECTOR		ADDRESS F. Gasch's Sons Hyattsville, Md.			25a. RECD BY REGISTRAR Charles Judge		25b. REGISTRAR'S SIGNATURE			
DATE NOV 18 1968										



**10 HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completed in full, it should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

Item 6 Film G406 11/13/68 kk MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16314

CERTIFICATE OF DEATH

16324

1. DECEASED-NAME (Type or print)	First <b>Anastasia</b>	Middle <b>G</b>	Last <b>Coward</b>	2a. DATE OF DEATH Month <b>November</b>	Doy <b>3</b>	Year <b>68</b>	2b. HOUR <b>8:30A</b>
3 SEX <b>Female</b>	4. RACE <b>Cauc.</b>	5. DATE OF BIRTH <b>NOV 7 1922</b>	6. AGE (In years last birthday <b>45 86 yrs.</b> )	IF UNDER 1 YEAR MONTHS <b>0</b>	IF UNDER 24 HRS HOURS <b>0</b>	MIN <b>0</b>	
7a. BIRTHPLACE (State or foreign country) <b>WASH. D.C.</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED	9. COUNTY OF DEATH <b>Prince Georges</b>	Md			
10. CITY OR TOWN OF DEATH <b>Cheverly</b>	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Prince Georges Gen. Hosp.</b>	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>HOUSEWIFE</b>	12b. KIND OF BUSINESS OR INDUSTRY				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Md.</b>	13c. CITY OR TOWN <b>Riverdale</b>	13d. INSIDE CITY LIMITS? <b>YES</b>	13e. STREET AND NUMBER <b>4701 Ravenswood Road</b>				
14. FATHER'S NAME First <b>CHARLES J.</b>	Middle <b>Smith</b>	Last	15. MOTHER'S MAIDEN NAME First <b>UNKNOWN</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <b>No</b>	16b. SOCIAL SECURITY NO <b>57746525C</b>	16c. INFORMANT <b>HUBERT WRIGHT</b>	Address <b>512 2nd St N.Y. N.Y.</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART 1 DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <b>5/18</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>Post Necrotic Cirrhosis of Liver</b>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
(b) DUE TO, OR AS A CONSEQUENCE OF <b>Viral Hepatitis</b>							
(c)							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>Ex</b>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? <input type="checkbox"/> YES	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State	
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>October 30, 1968</b> to <b>November 3, 1968</b> , that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on <b>Nov. 3 1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) <input type="checkbox"/> did not view the body after death.							
22b. SIGNATURE <b>Arnold Brody</b>							
22d. PHYSICIAN'S NAME (Type) <b>Arnold G. Brody, M. D.</b>		DEGREE <b>MD</b>	ATTENDING PHYS. <input checked="" type="checkbox"/>	MED DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input checked="" type="checkbox"/>	22c. DATE SIGNED <b>3 Nov 68</b>	
23a. BURIAL, CREMATION REMOVAL (Specify) <b>BURIAL</b>							
23b. DATE <b>11-6-68</b>		23c. NAME OF CEMETERY OR CREMATORIUM <b>WASH. NAT. CEM</b>	23d. LOCATION (City or Town) <b>SUITLAND</b>	(County) <b>MD.</b>	(State)		
24. FUNERAL DIRECTOR <b>WW CHAMBERS CO</b>		ADDRESS <b>1400 CHAPIN ST. N.W. WASH. D.C.</b>	25a. REC'D BY REGISTRAR DATE <b>NOV 8 1968</b>	25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			



## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## CERTIFICATE OF DEATH

16315

16315

**10 HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 DECEASED NAME (Type or print)	First Redman	Middle Haywood	Last Crouch	2a DATE OF DEATH Month Nov. 1968	2b HOUR 145 PM
3 SEX male	4 RACE white	S DATE OF BIRTH Aug 26, 1914	6 AGE (In years lost birthday) 54	IF UNDER 1 YEAR MONTHS	IF UNDER 24 HRS DAYS HOURS MIN
7a BIRTHPLACE (State or foreign country) Virginia	7b. CITIZEN OF WHAT COUNTRY? U S A	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Prince George's	Md	
10 CITY OR TOWN OF DEATH Hyattsville	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 6214 43rd ave		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Laboratory machinist	12b KIND OF BUSINESS OR INDUSTRY U S Gov't	
13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md	13b COUNTY Pro George's	13c CITY OR TOWN Hyattsville	13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e STREET AND NUMBER 6214 43rd Ave	
14 FATHER'S NAME First Arthur Crouch	Middle	Last	15 MOTHER'S MAIDEN NAME First Elizabeth Brooks	Middle	Last
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown no	16b. SOCIAL SECURITY NO. 577 10 9454	17 INFORMANT Mary M Crouch	Address Hyattsville, Md.	APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH P.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Cachexia</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a). (b) <i>Generalized carcinomatosis</i> 11-42 DUE TO, OR AS A CONSEQUENCE OF (c) <i>Carcinoma of Colon</i> about 14-40					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (o)					
MEDICAL CERTIFICATION		19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
		21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f LOCATION Street or R.F.D. No.	City or Town	County	State
22a I certify that (I) (this hospital) attended the deceased from <u>Nov. 11, 1968</u> , to <u>Nov. 13, 1968</u> , that (I) (we) last saw the deceased alive on <u>Nov. 11, 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <i>David S Clayman MD</i>		DEGREE ATTENDING PHYS	22c. DATE SIGNED Nov 13, 1968		
22d. PHYSICIAN'S NAME (Type)	David S Clayman	22e. ADDRESS 6311 Baltimore ave., Riverdale, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE Nov 16, 1968	23c. NAME OF CEMETERY OR CREMATORIUM Ft Lincoln Cemetery	23d. LOCATION (City or Town) Colmar Manor	(County) Pro Geo	(State) Md.
24. FUNERAL DIRECTOR F. Gasch's Sons	ADDRESS Hyattsville, Md.	25a. RECD BY REGISTRAR NOV 18 1968	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		



**HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**JO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal of the deceased.

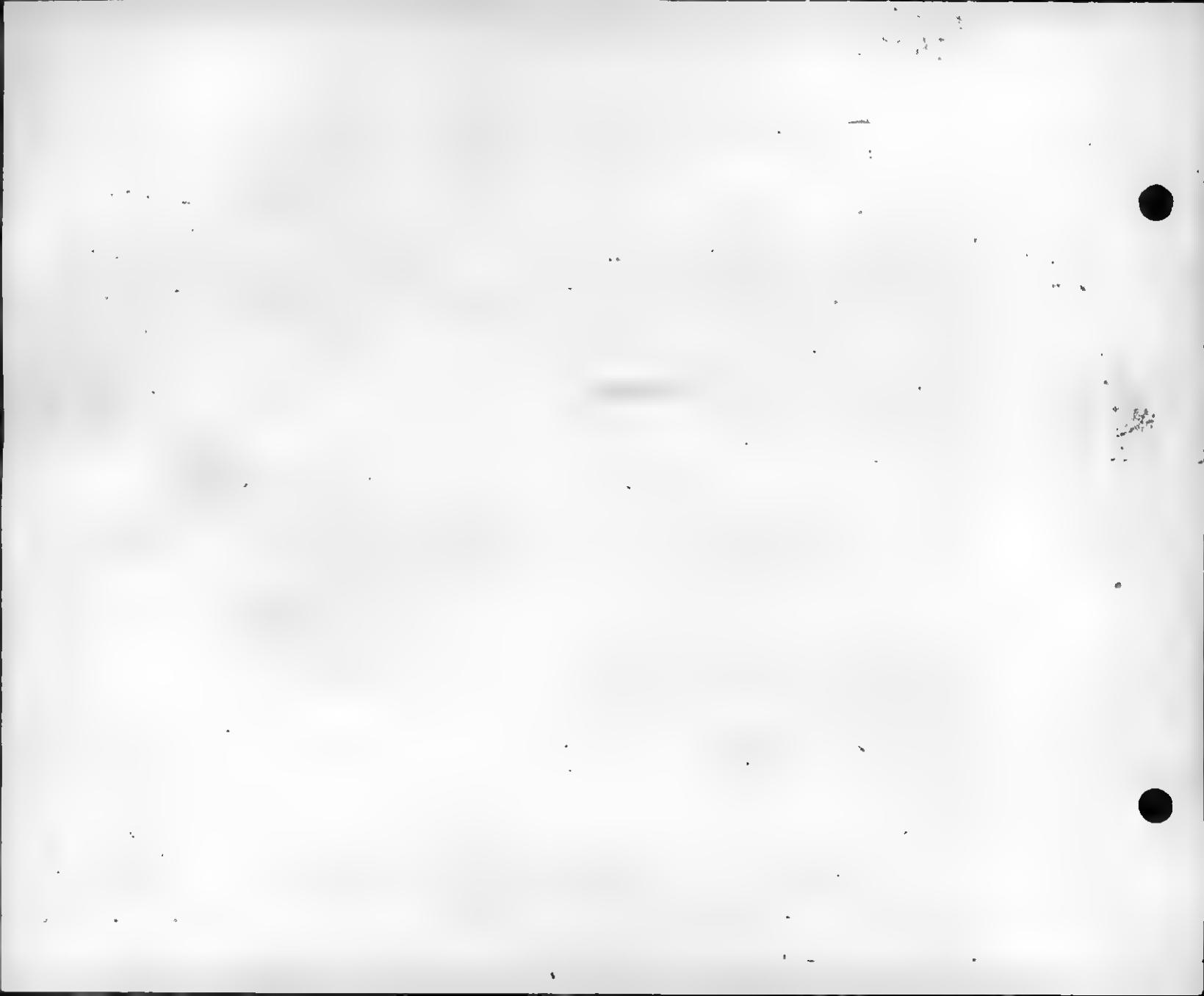
16316

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

16316

1 DECEASED NAME (Type or print)	First LAST <u>CURTIN</u>	Middle <u>A.</u>	Last FIRST <u>JAMES</u>	2a DATE OF DEATH Month Nov.	2b. HOUR Year 1968 9:00 AM
3. SEX <u>MALE</u>	4 RACE <u>WHITE</u>	S DATE OF BIRTH <u>JAN. 16, 1888</u>	6. AGE (in years last birthday) <u>80</u> YRS.	IF UNDER MONTHS	YEAR DAYS HOURS MIN
7a. BIRTHPLACE (State or foreign country) <u>Tash S C.</u>	7b. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9 COUNTY OF DEATH <u>PRINCE GEORGE</u>	Md	
10 CITY OR TOWN OF DEATH <u>BERKSHIRE</u>	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>7402 Hansford St.</u>	12a. LSSA OCCUPATION (Kind of work done during most of working life, even if retired) <u>Plumber</u>	12b. KIND OF BUSINESS OR INDUSTRY <u>Plumbing</u>		
13a. USJAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE <u>Md.</u>	13b. COUNTY <u>Pr. Geo.</u>	13c. CITY OR TOWN <u>Berkshire</u>	13d. INSIDE CITY LIMITS? <u>YES X</u>	13e. STREET AND NUMBER <u>7402 Hansford St.</u>	
14 FATHER'S NAME First <u>OLIVER</u>	Middle <u>CURTIN</u>	15 MOTHER'S MAIDEN NAME First <u>JOSEPHINE</u>	Middle <u>THOMAS</u>	Lost	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <u>No</u>	16b. SOCIAL SECURITY NO. <u>579-01-4650 A</u>	17 INFORMANT <u>Julia Schaub</u>	Address <u>7402 Hansford St. Berkshire</u>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>MASSIVE CEREBRAL HEMORRHAGE</u>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>7 Hours</u>		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>ARTERIO SCLEROTIC C.V DISEASE</u>			3 yr.		
DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c)					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(c)					
19a. MEDICAL CERTIFICATION DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? <input type="checkbox"/> YES <input type="checkbox"/> NO	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)		
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No	City or Town	County State
22a. I certify that (I) (this hospital) attended the deceased from saw the deceased alive on <u>Jan. 16, 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>Benjamin S. Person, M.D.</u>					
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS <u>6106 OLD SILVER HILL ROAD</u>		22f. DATE SIGNED <u>11-17-68</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>11-20-68</u>	23c. NAME OF CEMETERY OR CREMATORIUM <u>Cedar Hill Cemetery</u>	23d. LOCATION (City or Town) <u>Suitland</u>	(County) <u>Pr. Geo.</u> (State) <u>Md.</u>
24. FUNERAL DIRECTOR Wilhelm Funeral Home			ADDRESS <u>Suitland, Md.</u>	25a. REC'D. BY REGISTRAR <u>NOV 1 1968</u>	25b. REGISTRAR'S SIGNATURE <u>Charles Young</u>



FOR STATE  
HEALTH DEPT

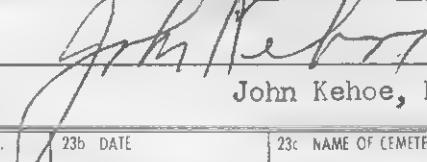
16313

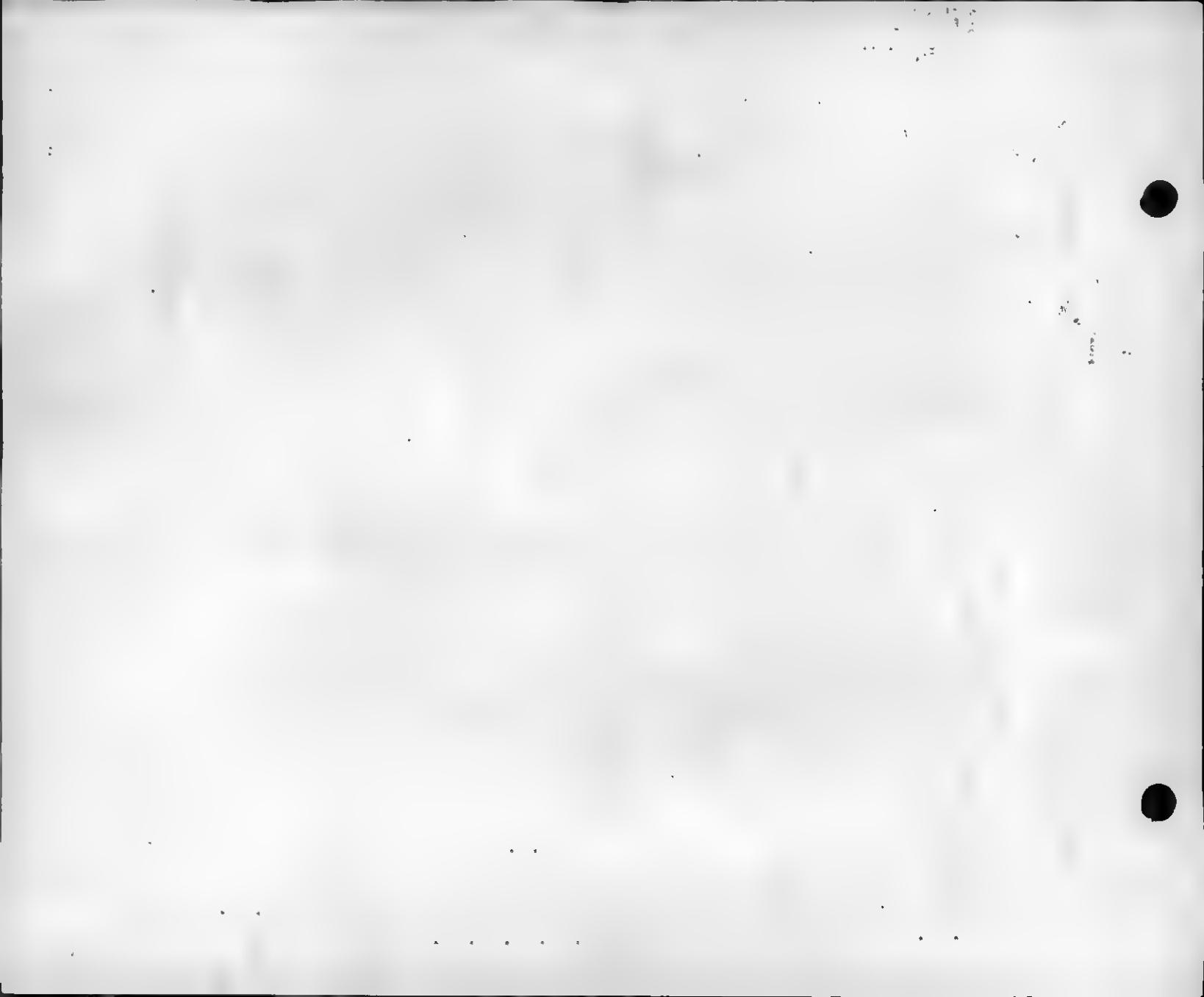
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
Item 18 Film 409 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

153.2

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with farm PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal; and in any event within 72 hours after death.

1 DECEASED NAME (Type or Print)		First Nathaniel	Middle Daniels	Last Daniels	2a DATE KNOWN OF ESTI. DEATH MATED <input checked="" type="checkbox"/> 11 27 68	Month Year 11 68	Day Year 27 68	2b HOUR AM 1:00
3 SEX M	4 RACE Negro	5 DATE OF BIRTH 29 May 42	6 AGE (In years last birthday) 26 yrs	F UNDER MONTHS OAYS HOURS MIN	7 DATE PRONOUNCED DEAD Month 11 Day 27 Year 19 68	2d HOUR 8:00 AM		
7a BIRTHPLACE (State or foreign country) North Carolina		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	9. COUNTY OF DEATH Prince George		10b KIND OF BUSINESS OR INDUSTRY Md	
10. CITY OR TOWN OF DEATH Cheverly		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Prince George Hosp			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if ref.red)		12b. KIND OF BUSINESS OR INDUSTRY	
13a JSLAL RESIDENCE (Where deceased lived, if institution Res dence before admission) STATE Md		13c CITY OR TOWN Prince George Hyattsville		13d INSIDE CITY LIMITS <input checked="" type="checkbox"/> NO	13e STREET AND NUMBER Burlington Rd.			
14. FATHER'S NAME Joseph		Middle Daniels	Last Daniels	15. MOTHER'S MAIDEN NAME Noami	Middle	Last Grissom		
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b SOCIAL SECURITY NO. (If yes give war or dates of service)		17. INFORMANT		ADDRESS		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Heart failure						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Minutes
4129 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last		DUE TO, OR AS A CONSEQUENCE OF A S H D						
(b)		DUE TO, OR AS A CONSEQUENCE OF						
(c)								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)								
420C		19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED?		20 AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)				
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f LOCATION Street or R.F.D. No		City or Town	County	State
22a I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>								
ACTUAL SIGNATURE 		John Kehoe, M.D., Riverdale		CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D.	ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	22b DATE SIGNED 11-28-68		
EXAMINER'S NAME (Type)				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	ADDRESS (Street, city, town, or county)			
23a BURIAL, CREMATION, REMOVAL (Specify) removal		23b DATE 11-30-68		23c NAME OF CEMETERY OR CREMATORIAL Durham, N. C.		23d LOCATION (City or Town) (County) (State)		
24 FUNERAL DIRECTOR R. N. Norton Inc		ADDRESS 1324 You, St. N. W. D. C.		25a. RECEIVED BY REGISTRAR DATE DEC 2 1968		25b. REGISTRAR'S SIGNATURE Charles Judge		



MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

1633

CERTIFICATE OF DEATH

**10 HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.  
**Page 4 may be retained by the hospital or attending physician**  
**11 FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers - Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 DECEASED NAME (Type or print)		First <b>Carey</b>	Middle <b>T.</b>	Last <b>David Sr.</b>	2a. DATE OF DEATH Month <b>11</b>	Day <b>12</b>	Year <b>68</b>	2b. HOUR <b>M</b>
3 SEX <b>Male</b>	4 RACE <b>Caucasian</b>	5. DATE OF BIRTH <b>July 8, 1897</b>			6. AGE (In years last birthday) <b>71</b> YRS	IF UNDER 1 YEAR MONTHS <b>0</b>	IF UNDER 24 HRS HOURS <b>0</b>	MIN <b>0</b>
7a. BIRTHPLACE (State or foreign country) <b>SC</b>	7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	8 MARRIED <input checked="" type="checkbox"/>	NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/>	DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH <b>Prince George's</b>		
10. CITY OR TOWN OF DEATH <b>College Park</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Leland Hospital</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if part time) <b>Retired Post Office</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>U.S. Gov't</b>
13a. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) <b>Maryland</b>	13b. COUNTY <b>Prince George</b>	13c. CITY OR TOWN <b>College Park</b>			13d. INSURANCE CITY LIM TS? <b>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></b>	13e. STREET AND NUMBER <b>8417 Patuxent Avenue</b>		
14. FATHER'S NAME First <b>Wm R. David</b>		Middle	Last	15. MOTHER'S MAIDEN NAME First ? Middle <b>Parker</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <b>yes</b>	16b. SOCIAL SECURITY NO. <b>216 44 9452</b>	17. INFORMANT <b>Margaret W David</b>			Address <b>College Park, Md.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Severe stenosing coronary arteriosclerosis with complete occlusion of right branch.</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any which gave rise to immediate cause (a), stating the underlying cause (b) <b>Severe arteriosclerotic heart disease with extensive myocardial fibrosis.</b> DUE TO, OR AS A CONSEQUENCE OF (c)								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) (severe) <b>Pulmonary edema (severe); old cerebral infarction; generalized arteriosclerosis.</b>								
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? <b>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></b>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>Yes</b>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No	City or Town		County	State		
22a. I certify that (I) <input checked="" type="checkbox"/> was hospitalized the deceased from <b>10-8-63</b> , 19 <b>63</b> , to <b>11-12</b> , 19 <b>68</b> , that (I) <input checked="" type="checkbox"/> last saw the deceased alive on <b>11-1-68</b> , 19 <b>68</b> , and that in (my) <input checked="" type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above, (I) <input checked="" type="checkbox"/> did (did not) view the body after death.								
22b. SIGNATURE <i>William B. Gunther</i>	DEGREE <input checked="" type="checkbox"/> ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22c. DATE SIGNED <b>11-13-68</b>						
22d. PHYSICIAN'S NAME (Type) <b>William B. Gunther, M. D.</b>	22e. ADDRESS <b>4917 Edgewood Road, College Park, Md.</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>Nov 16, 1968</b>	23c. NAME OF CEMETERY OR CREMATORIAL <b>Ft Lincoln Cemetery</b>	23d. LOCATION (City or Town) <b>Colmar Manor</b>			(County) <b>Pro Geo</b>	(State) <b>Md.</b>	
24. FUNERAL DIRECTOR <b>F. Gasch's Sons</b>	ADDRESS <b>Hyllattsville, Md.</b>	25a. REC'D BY REGISTRAR <b>Charles George</b>			25b. REGISTRAR'S SIGNATURE <b>Charles George</b>			

100-1000

**HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be submitted within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

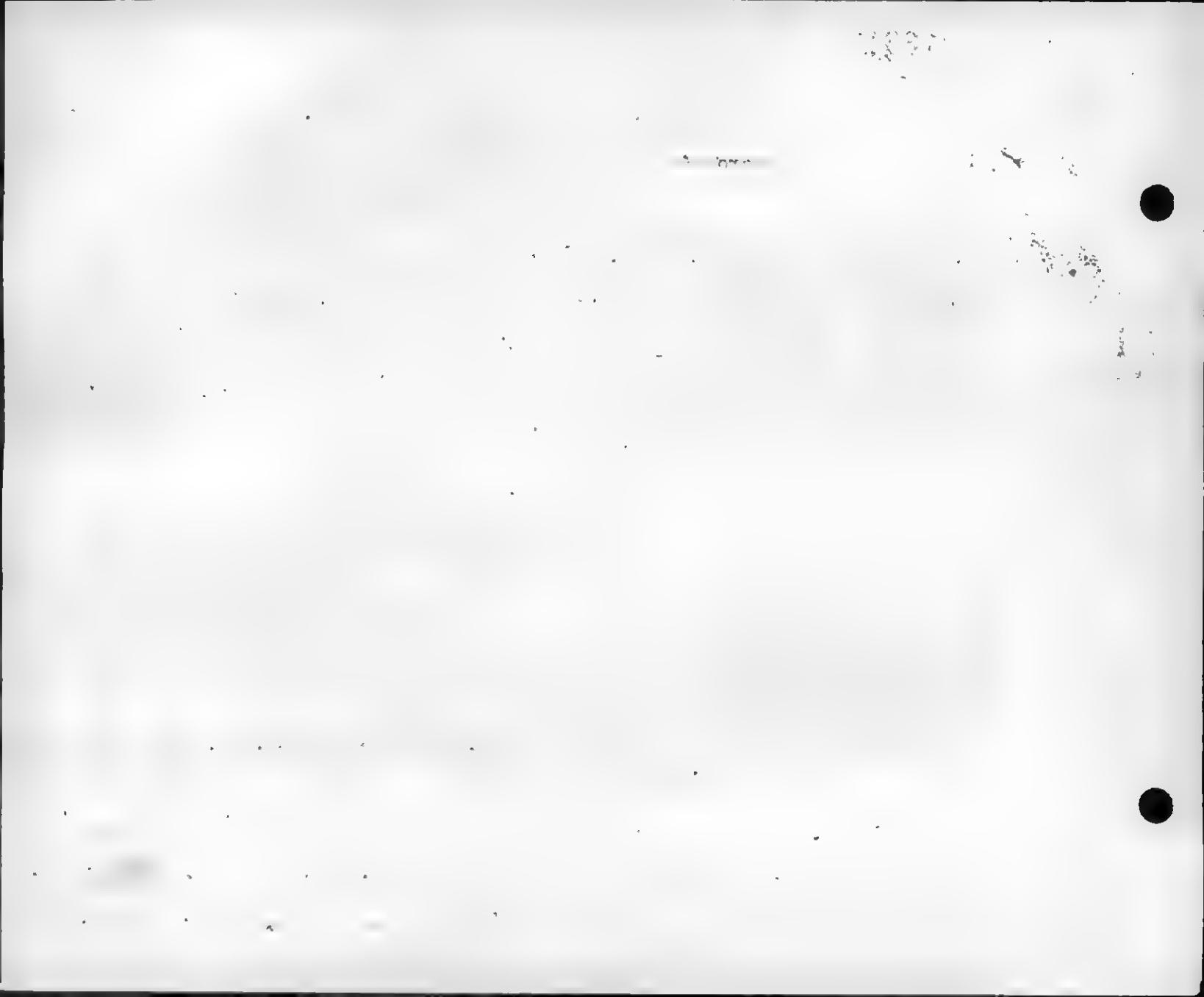
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

1633.

Item #23a, Film #407 12/3/68 km

**CERTIFICATE OF DEATH**

1. DECEASED-NAME (Type or print)	First  Mary	Middle  D.	Last  Davis	20. DATE OF DEATH Month Nov. 11, 1968 Year	2b. HOUR 2:24 P M
3. SEX  Female	4. RACE  Negro	S. DATE OF BIRTH  8/30/68	6. AGE (In years lost birthday) YRS. 2	IF UNDER 1 YEAR MONTHS 2	F. UNDER 24 HRS. DAYS HOURS MIN
7a. BIRTHPLACE (State or foreign country)  Pr. Geo. Co. Md.	7b. CITIZEN OF WHAT COUNTRY?  Prince Geo. Gen'l Hospital	8. MARRIED WIDOWED NEVER MARRIED DIVORCED <input checked="" type="checkbox"/>	9. COUNTY OF DEATH  Prince George's	Md	
10. CITY OR TOWN OF DEATH  Cheverly	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)  Prince Geo. Gen'l Hospital	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)	12b. KIND OF BUSINESS OR INDUSTRY		
13a. RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE Maryland	13b. COUNTY Prince George's Upper Marlboro	13c. CITY OR TOWN Prince George's Upper Marlboro	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER Box 3572	
14. FATHER'S NAME  Thomas	First  Davis	15. MOTHER'S MAIDEN NAME  Mary Louise	Middle  Pinkney	Address Thomas Davis - See above	Last
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown)	16b. SOCIAL SECURITY NO	17. INFORMANT Thomas Davis	APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Bacterial meningitis</u> 3201 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Pneumococcal Infection</u> DUE TO, OR AS A CONSEQUENCE OF (c)					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) 70.					
19a. DATE OF OPERATION  MEDICAL CERTIFICATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from Nov. 10, 1968, to Nov. 11, 1968, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on Nov. 11, 1968, and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) did <input checked="" type="checkbox"/> did not view the body after death					
22b. SIGNATURE  Edwin Jensen, M.D.	DEGREE ATTENDING PHYS	MED. DIRECTOR <input checked="" type="checkbox"/>	STAFF PHYS <input type="checkbox"/>	22c. DATE SIGNED Nov. 12, 1968	
22d. PHYSICIAN'S NAME (Type)  Edwin J. Jensen, M. D.	22e. ADDRESS  Prince Geo. Gen'l Hospital, Cheverly, Md.				
23a. BURIAL, CREMATION, REMOVAL (Specify) 1	23b. DATE 11/14/68	23c. NAME OF CEMETERY OR CREMATORIAL ST. Peter's Cemetery, Walkers, Charles, Md.	23d. LOCATION (City or Town) (County) (State)		
24. FUNERAL DIRECTOR  Marvin Adams Aquino	ADDRESS 20608	25a. REC'D. BY REGISTRAR DATE NOV 25 1968	25b. REGISTRAR'S SIGNATURE Charles Judge		
VR A15 (4) 30M REV. 1/68					



FOR STATE  
HEALTH DEPT.



**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death if necessary; please execute the certificate, writing the word "pending" in pencil in Item 18. Give forms 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 5 may be retained for your files.

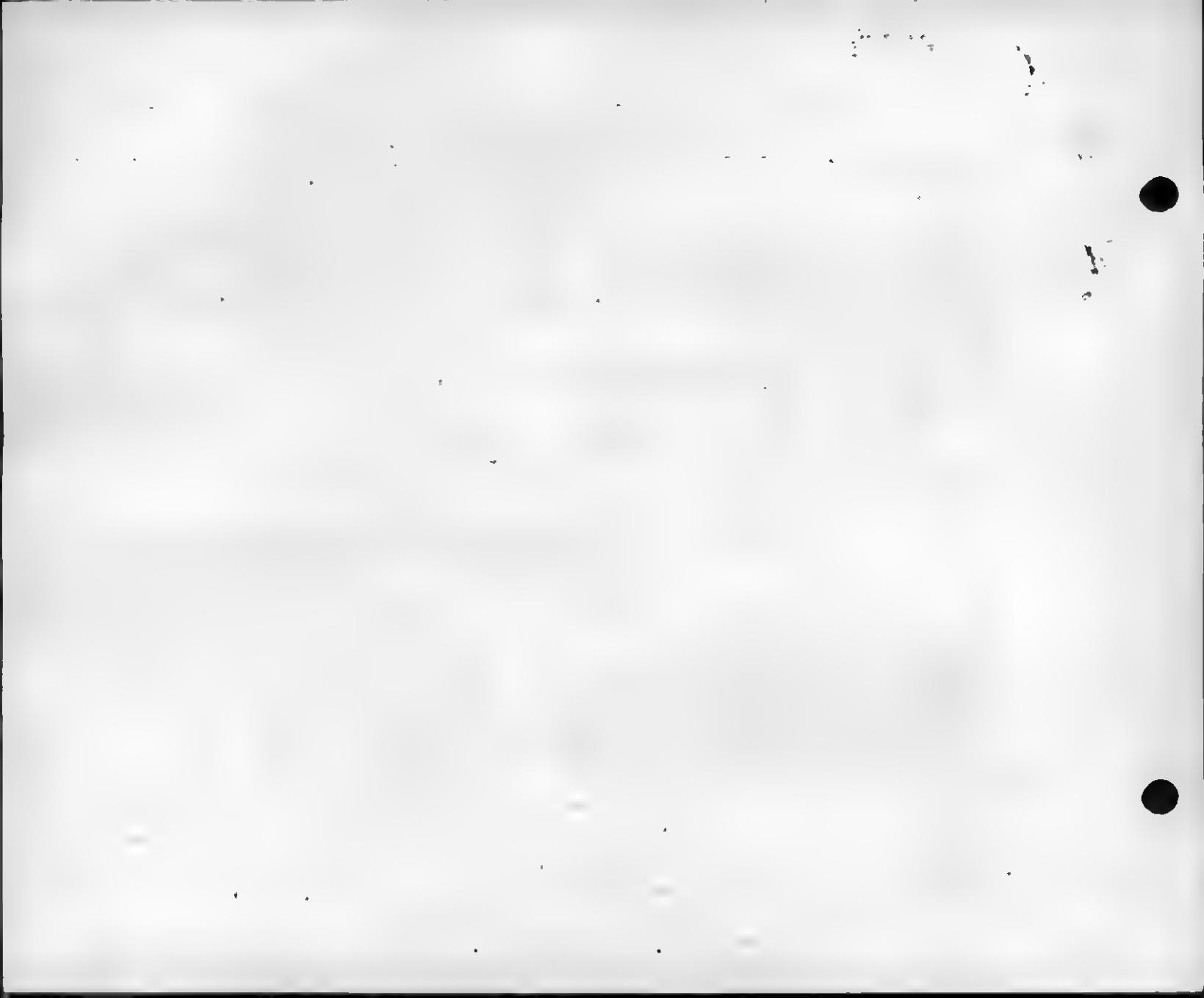
**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

16334

1 DECEASED NAME (Type or Print)		First Michael	Middle John	Last Demma	2a DATE KNOWN OF EST. DEATH MATED <input checked="" type="checkbox"/>	Month 11	Day 29	Year 1968	2b HOUR 12:30pm		
3 SEX Male	4 RACE White	S. DATE OF BIRTH 2-21-1909	6 AGE (In years last birthday) 59 yrs	IF UNDER 1 YEAR MONTHS 0	IF UNDER 24 HRS DAYS 0	HOURS 0	MIN. 0		2d HOUR 2d HOUR		
7a BIRTHPLACE (State or foreign country) D.C.	7b CITIZEN OF WHAT COUNTRY? USA	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9 COUNTY OF DEATH Prince George's Md								
10 CITY OR TOWN OF DEATH Cheverly		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Prince George Hospital			12a USUAL OCCUPATION (Kind of work done or kind of working life even if retired) Sales girl in pldg			12b KIND OF BUSINESS OR INDUSTRY Jewelry			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Prince George's Mt. Rainier		13d. INSIDE CITY, MTS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER 3208 35th. Street					
14 FATHER'S NAME Frank Demma		First	Middle	Last	15 MOTHER'S MAIDEN NAME Lucy	First	Middle	Last			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) YES		16b. SOCIAL SECURITY NO. 578148902		17. INFORMANT Mary C. Demma (Wife) Same as # 13		ADDRESS					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Intra cerebral hemorrhage DOUE TO, OR AS A CONSEQUENCE OF Hypertensive vascular disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DOUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20 AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. _____ City or Town _____ County _____ State _____							
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>										CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D.	
										ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ADDRESS (Street, city, town, or county) _____	22b. DATE SIGNED 11-30-68
23a. BURIAL CREMATION CREMATORIUM (Specify) BEMRAVIA		23b. DATE 12-3-68		23c. NAME OF CEMETERY OR CREMATORIUM Mt. Olivet Cemetery		23d. LOCATION (City or Town) Washington, D.C.		(County) (State)			
24. FUNERAL DIRECTOR Name (Type) Nalley Funeral Home, Mt. Rainier, Md.		ADDRESS Nalley Funeral Home, Mt. Rainier, Md.		25a. REC'D BY REGISTRAR Date DEC 5 1968		25b. REGISTRAR'S SIGNATURE Charles Judge					



**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-trust permit. Then please remove carbon papers. Page 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH										1633
1 DECEASED NAME (Type or print)	First WAGNER	Middle WARNER	Last DICK	2a DATE OF DEATH Month NOV	25 Day 1968 Year	2b. HOUR 2:40 M				
3. SEX MALE	4. RACE CAUCASIAN	S. DATE OF BIRTH 17 FEB 1920	6 AGE (In years last birthday) 48 yrs	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN					
7a BIRTHPLACE (State or foreign country) IA.	7b CITIZEN OF WHAT COUNTRY? U.S.A.	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9 COUNTY OF DEATH PRINCE GEORGE'S							
10 CITY OR TOWN OF DEATH ANDREWS AFB	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) MALCOLM GROW USAFHOSP	12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) PILOT	12b KIND OF BUSINESS OR INDUSTRY USAF							
13a USJAL RESIDENCE (Where deceased lived, if institution, residence before admission) STATE VIRGINIA	13b COUNTY Fairfax	13c CITY OR TOWN ANNADALE	13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e STREET AND NUMBER 3602 DRUID LANE						
14. FATHER'S NAME First MATTHEW	Middle W.	Last DICK	15. MOTHER'S MAIDEN NAME First JESSE	Middle P.	Last EASLEY					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> or unknown 1941-1968	16b. SOCIAL SECURITY NO. 439-035-672	17. INFORMANT WIFE	Address SAME AS ITEM # 13							
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>RESPIRATORY ARREST</b>						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
150X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.	DUE TO, OR AS A CONSEQUENCE OF (b) <b>WIDE SPREAD CARCINOMA OF THE ESOPHAGUS</b>					3 Months				
DUE TO, OR AS A CONSEQUENCE OF (c)										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
19a DATE OF OPERATION 150X	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
MEDICAL CERTIFICATION		21a ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)						
		21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work	21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)	21f LOCATION Street or R.F.D. No.	City or Town	County	State			
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>August</u> , 19 <u>68</u> , to <u>25 Nov</u> , 19 <u>68</u> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>25 Nov</u> , 19 <u>68</u> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) <input type="checkbox"/> (did not) view the body after death.										
22b. SIGNATURE <i>B. Graham</i>		DEGREE ATTENDING PHYS.	<input type="checkbox"/>	MED. DIRECTOR	<input type="checkbox"/>	STAFF PHYS	<input checked="" type="checkbox"/>	22c. DATE SIGNED 25 Nov 68		
22d. PHYSICIAN'S NAME NAME GRAHAM, CAPT, USAF, MC		22e. ADDRESS MALCOLM GROW USAF HOSP ANDREWS AFB MD								
23a. BURIAL/CREMATION, REMOVAL (Specify) Burial	23b. DATE 11-30-68	23c. NAME OF CEMETERY OR CREMATORIAL Greenwood Cemetery	23d. LOCATION (City or Town) New Orleans La.	(County)		(State)				
24. FUNERAL DIRECTOR ADDRESS Mr. W. Chambers Co. 517-11 St. A.E. D.C.	25. REC'D BY REGISTRAR DATE DEC 2 1968	26. REGISTRAR'S SIGNATURE Charles Judge	25b. REGISTRAR'S SIGNATURE							



16328

## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item #6, Film #6 11/22/68 km

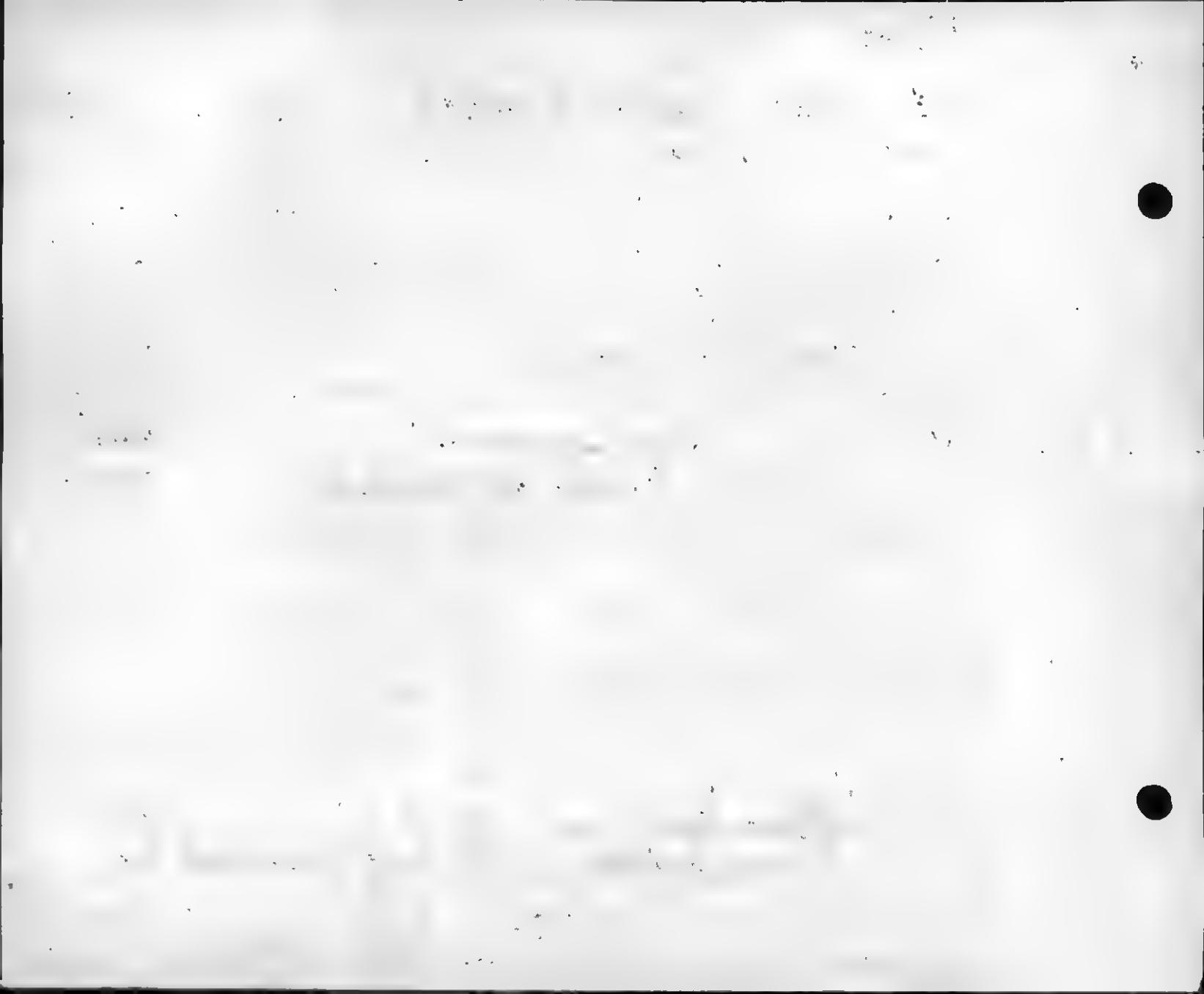
16328;

## CERTIFICATE OF DEATH

**10 HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.  
 Page 4 may be retained by the hospital or attending physician.

**10 FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper 3 from pages 1 and 2, so that it can be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 DECEASED NAME (Type or print)	First James	Middle Stchil	Last DiGregory	2a DATE OF DEATH Month Nov.	Day 11	Year 1968	2b HOUR 8:30 AM	
3 SEX Male	4 RACE White	S. DATE OF BIRTH January 1, 1929	6 AGE (In years lost birthday) 38 yrs.	IF UNDER 1 YEAR MONTHS 0	IF UNDER 24 HRS DAYS 0	HOURS 0	MIN. 0	
7a. BIRTHPLACE (State or foreign country) Illinois	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED	9. COUNTY OF DEATH Prince George Md					
10. CITY OR TOWN OF DEATH Bowie	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 7800 Chestnut Ave	12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Engineer	12b KIND OF BUSINESS OR INDUSTRY Salesman					
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Md	13b COUNTY P.G.	13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	13e. STREET AND NUMBER 7800 Chestnut Avenue					
14 FATHER'S NAME Angela DiGregory	15. MOTHER'S MAIDEN NAME Santa Demarco							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown Yes	16b. SOCIAL SECURITY NO. 1955-1957	17. INFORMANT Dorothy DiGregory						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) <b>PART I. DEATH WAS CAUSED BY.</b> <b>IMMEDIATE CAUSE (a)</b> <i>Carcinomatosis</i>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Weeks Several months				
<small>DUE TO, OR AS A CONSEQUENCE OF</small> <small>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause</small> <small>(b)</small> <small>DUE TO, OR AS A CONSEQUENCE OF</small> <small>lost.</small> <small>(c)</small>								
<b>PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)</b>								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <small>If either, notify medical examiner</small>		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION Street or R.F.D. No.	City or Town	County	State	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE <i>H. James Kurtz MD</i>				22c. DATE SIGNED 11/11/68				
22d. PHYSICIAN'S NAME (Type) H. James Kurtz		22e. ADDRESS RFD #1 Glenn Dale Md						
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 11-14-68	23c. NAME OF CEMETERY OR CREMATORIUM Resurrection Cemetery	23d. LOCATION (City or Town) Clinton PG Md					
24. FUNERAL DIRECTOR Doradoan Funeral Home Laurel		ADDRESS Laurel	25a. REC'D BY REGISTRAR DATE NOV 18 1968	25b. REGISTRAR'S SIGNATURE Charles Judge				



## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## CERTIFICATE OF DEATH

1633

To HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

To FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it may be retained by the hospital or attending physician. Then please remove carbon paper and sign page 3. If you do not have a burial-transit permit, then please attach a copy of your permit. Then please, remove carbon paper and sign page 3. This certificate should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print)	First HARVEY	Middle CHARLES	Last DORNEY	2a. DATE OF DEATH Month NOVEMBER	Day 13	Year 68	2b. HOUR 2045M
3. SEX MALE	4. RACE CAUCASIAN	S. DATE OF BIRTH 4 Nov 1912	6. AGE (In years last birthday) 56 YRS	IF UNDER 1 YEAR MONTHS 0		IF UNDER 24 HRS. DAYS 9	
7a. BIRTHPLACE (State or foreign country) OKLAHOMA'S	7b. CITIZEN OF WHAT COUNTRY? UNITED STATES	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH PRINCE GEORGE				
10. CITY OR TOWN OF DEATH ANDREWS AIR FORCE BASE	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) MALCOLM GROW HOSP		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) BOMBER PILOT	12b. KIND OF BUSINESS OR INDUSTRY U.S.A.F.			
13a. JUSUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE ILLINOIS	13c. CITY OR TOWN RICHLAND	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 221 WEST CHESTNUT STREET				
14. FATHER'S NAME HARVEY	First CHARLES	Middle DORNEY JR.	Last	15. MOTHER'S MAIDEN NAME MATILDA	Middle AGNES	Last MEHMERT	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown YES	16b. SOCIAL SECURITY NO. (If yes give war or dates of service) 320 3469 32	17. INFORMANT MRS DOROTHY A. DORNEY	Address CAMP SPRINGS MD.		20331 APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Calcaronatosis</i> 1519 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>carcinoma of the stomach</i> DUE TO, OR AS A CONSEQUENCE OF (c)							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>bowel obstruction</i>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State	
22a. I certify that (I) (This hospital) attended the deceased from <u>25 Sep</u> , 19 <u>68</u> , to <u>13 Nov</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>13 Nov</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>David A. Morowitz, MD</i>		DEGREE ATTENDING PHYS.	<input checked="" type="checkbox"/> MED DIRECTOR	<input type="checkbox"/> STAFF PHYS.	22c. DATE SIGNED <u>13 Nov. 68</u>		
22d. PHYSICIAN'S NAME (Type) DAVID A. MOROWITZ		22e. ADDRESS MALCOLM GROW USAF HOSPITAL ANDREWS AFB, WASHINGTON, D.C. 20331					
23a. BURIAL/CREMATION, REMOVAL (Specify) Burial		23b. DATE 11-15-68	23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS <i>Arlington National Cemetery, Arlington, Virginia</i>	23d. LOCATION (City or Town) (County) (State)			
24. F.JNERAL DIRECTOR W. W. Chambers Jr.		25a. REC'D BY REGISTRAR DATE NOV 18 1968 25b. REGISTRAR'S SIGNATURE <i>Charles J. Moore</i>					



MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16324

CERTIFICATE OF DEATH

16324

**10 HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.  
**Page 4 may be retained by the hospital or attending physician.**

**10 FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove certain papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print)		First <b>Philip</b>	Middle <b>C.</b>	Last <b>Dorr</b>	2a DATE OF DEATH Month <b>Nov.</b>	Day <b>30</b>	Year <b>68</b>	2b. HOUR <b>6:30PM</b>							
3 SEX <b>Male</b>		4. RACE <b>Cauc.</b>		5. DATE OF BIRTH <b>06-19-93</b>		6 AGE (in years last birthday) <b>75 YRS.</b>		IF UNDER 1 YEAR MONTHS <b>0</b>		IF UNDER 24 HRS HOURS <b>0</b>		MIN <b>0</b>			
7a. BIRTHPLACE (State or foreign country) <b>Illinois</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH <b>Prince Georges</b>									
10 CITY OR TOWN OF DEATH <b>Cheverly</b>		11 NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) <b>Prince Georges Gen. Hosp.</b>		12a. USJAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>R.R. Supt. S. Govt.</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>None</b>									
13a USUAL RESIDENCE (Where deceased lived, if institution Resdence before admission) STATE <b>Md.</b>		13c. CITY OR TOWN <b>Prince Georges Mt. Rainier</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <b>3808 32nd Street</b>									
14. FATHER'S NAME First <b>Clarence Dorr</b>		15. MOTHER'S MAIDEN NAME First <b>Mary Shattuck</b>													
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown? <b>Yes</b>		16b. SOCIAL SECURITY NO. <b>WWII</b>		17. INFORMANT <b>Ruby V. Dorr - above address</b>		Address									
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>1530 Ventricular Fibrillation (3 hrs post surgical)</b>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>3 hrs</b>							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last <b>1530</b>		DUE TO, OR AS A CONSEQUENCE OF (b) <b>Carcinoma of Cessum</b>		DUE TO, OR AS A CONSEQUENCE OF (c)				44 days							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) <b>Complete Pectoralis Dissection, Abdominal Hernia</b>															
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?									
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)											
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No City or Town County State											
22a. I certify that <input type="checkbox"/> (this hospital) attended the deceased from <b>Oct. 14, 1968</b> , to <b>Nov. 30, 1968</b> , that <input type="checkbox"/> (we) last saw the deceased alive on <b>Nov. 30, 1968</b> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input type="checkbox"/> (we) (did) <input type="checkbox"/> (did not) view the body after death.															
22b. SIGNATURE <b>Jerome Sandler, M.D.</b>		22c. DEGREE ATTENDING PHYS.		22d. MED. DIRECTOR		22e. STAFF PHYS.		22f. DATE SIGNED <b>12/1/68</b>							
22d. PHYSICIAN'S NAME (Type) <b>Jerome Sandler, M.D.</b>		22e. ADDRESS <b>106 Irving St., NW, Washington, DC 20010</b>													
23a. BURIAL CREMATION, Crematory (Specify) <b>Burial</b>		23b. DATE <b>12/4/68</b>		23c. NAME OF CEMETERY OR CREMATORIAL <b>Forest Hill Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Suitland, Md.</b>									
24. FUNERAL DIRECTOR <b>Miller Funeral Home Mt. Rainier, Md.</b>		ADDRESS <b>106 Irving St., NW, Washington, DC 20010</b>		25a. RECD BY REGISTRAR DATE <b>DEC 5 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>									
VR A1 45M															



## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## CERTIFICATE OF DEATH

16325

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.  
**Page 4 may be retained by the hospital or attending physician.**

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers pages 1 and 2 and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print)	First Herman	Middle Bradford	Last Dudley	2a. DATE OF DEATH Month 11-13	Day 68	Year 1968	2b. HOUR 9:30 AM		
3 SEX Male	4 RACE White	5. DATE OF BIRTH 3-15-90		6 AGE (In years last birthday) 78	IF UNDER MONTHS YRS	YEAR DAYS	IF UNDER 24 HRS HOURS MIN		
7a. BIRTHPLACE (State or foreign country) Virginia	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>	9 COUNTY OF DEATH Prince George					
10. CITY OR TOWN OF DEATH Riverdale	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Eugene Leland Memorial			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Mail clerk	12b KIND OF BUSINESS OR INDUSTRY Penna R R				
13a USUAL RESIDENCE (Where deceased lived, if institut on: Residence before admission) STATE Maryland	13b. COUNTY Prince George	13c CITY OR TOWN W. Hyattsville	13d INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	13e STREET AND NUMBER 2011 Oglethorpe St.,					
14. FATHER'S NAME First Herman	Middle B.	Last Dudley Sr.	15 MOTHER'S MAIDEN NAME First	Middle Last					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown no	16b SOCIAL SECURITY NO 579 24 2722	17. INFORMANT Son and Medical Records	Address						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) <b>PART 1. DEATH WAS CAUSED BY</b> <b>IMMEDIATE CAUSE (a)</b> 284X DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <b>(b)</b> DUE TO, OR AS A CONSEQUENCE OF <b>(c)</b> <b>PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)</b>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)	21f. LOCATION Street or R.F.D. No. _____ City or Town _____ County _____ State _____						
22a. I certify that (I) (this hospital) attended the deceased from Sept 1, 1968, to Nov 13, 1968, that (I) (we) last saw the deceased alive on Nov 13, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								22c. DATE SIGNED 11-13-68	
22b. SIGNATURE <i>L.W. Malin</i>		DEGREE ATTENDING PHYS	<input checked="" type="checkbox"/> MED DIRECTOR	STAFF PHYS. <input type="checkbox"/>					
22d. PHYSICIAN'S NAME (Type) L.W. Malin, M.D.		22e. ADDRESS 440 Queensbury Rd., Riverdale, Md.							
23a. BURIAL CREMATION, REMOVAL (Specify) Burial	23b. DATE Nov 15, 1968	23c. NAME OF CEMETERY OR CREMATORIUM Ft Lincoln Cemetery	23d. LOCATION (City or Town) Colmar Manor Pro Geo	(County) Md.	(State) Md.				
24. FUNERAL DIRECTOR F. Gasch's Sons	ADDRESS Hyattsville, Md.	25a. REC'D BY REGISTRAR DATE NOV 18 1968	25b. REGISTRAR'S SIGNATURE <i>Charles J. Gasch</i>						



MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
**CERTIFICATE OF DEATH**

18533

**10 HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

**Page 4 may be retained by the hospital or attending physician.**  
**10 FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician or attending physician's director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DECEASED NAME (Type or print)	First Emma	Middle D.	Lost Duncan	2a. DATE OF DEATH Month November	Day 1	Year 1968	2b. HOUR 3 A.M.			
3 SEX Female	4 RACE Negro	5 DATE OF BIRTH May 6, 1895		6 AGE (In years last birthday) 72 YRS.		IF UNDER MONTHS 1	YEAR DAYS 1	IF UNDER 24 HRS HOURS 3	MIN 0	
7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Prince George's						
10 CITY OR TOWN OF DEATH Cheverly		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Prince George's Gen'l Hosp.		12a. USUAL OCCUPATION (kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY				
13a. USUAL RESIDENCE (Where deceased lived, if institution Residene before admission) STATE Maryland	13b. COUNTY Prince George's	13c. CITY OR TOWN Highland Park		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 1202 78th Avenue					
14 FATHER'S NAME First	Middle	Lost	15 MOTHER'S MAIDEN NAME First	Middle	Last					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown)		16b. SOCIAL SECURITY NO	17 INFORMANT		Address					
18 CAUSE OF DEATH (Enter on a line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Broncho-pneumonia ) right side.</u> 42-7 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause (b) <u>Massive cerebral infarct - right hemisphere-old and new</u> DUE TO, OR AS A CONSEQUENCE OF (c)						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 33.2X										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes				
21a ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)						
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f LOCATION Street or R.F.D. No		City or Town	County	State		
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from Sept. 27, 1968, to Nov. 1, 1968, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on Nov. 1, 1968, and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) <input checked="" type="checkbox"/> (did) <input checked="" type="checkbox"/> view the body after death.										
22b. SIGNATURE <u>Joselito Magday, M.D.</u>		22c. DATE SIGNED Nov. 1, 1968								
22d. PHYSICIAN'S NAME (Type) Joselito D. Magday, M. D.		22e. ADDRESS Prince George's General Hosp. Maryland		Cheverly						
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE Nov. 5, 1968		23c. NAME OF CEMETERY OR CREMATORIAL Harmony Memorial		23d. LOCATION (City or Town) Prince George's County, Md.		(County) (State)		
24. FUNERAL DIRECTOR Brown & Davidson		ADDRESS 5635 Eads St., N. E.		25a. REC'D BY REGISTRAR DATE MAR 6 1969		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>				



## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## CERTIFICATE OF DEATH

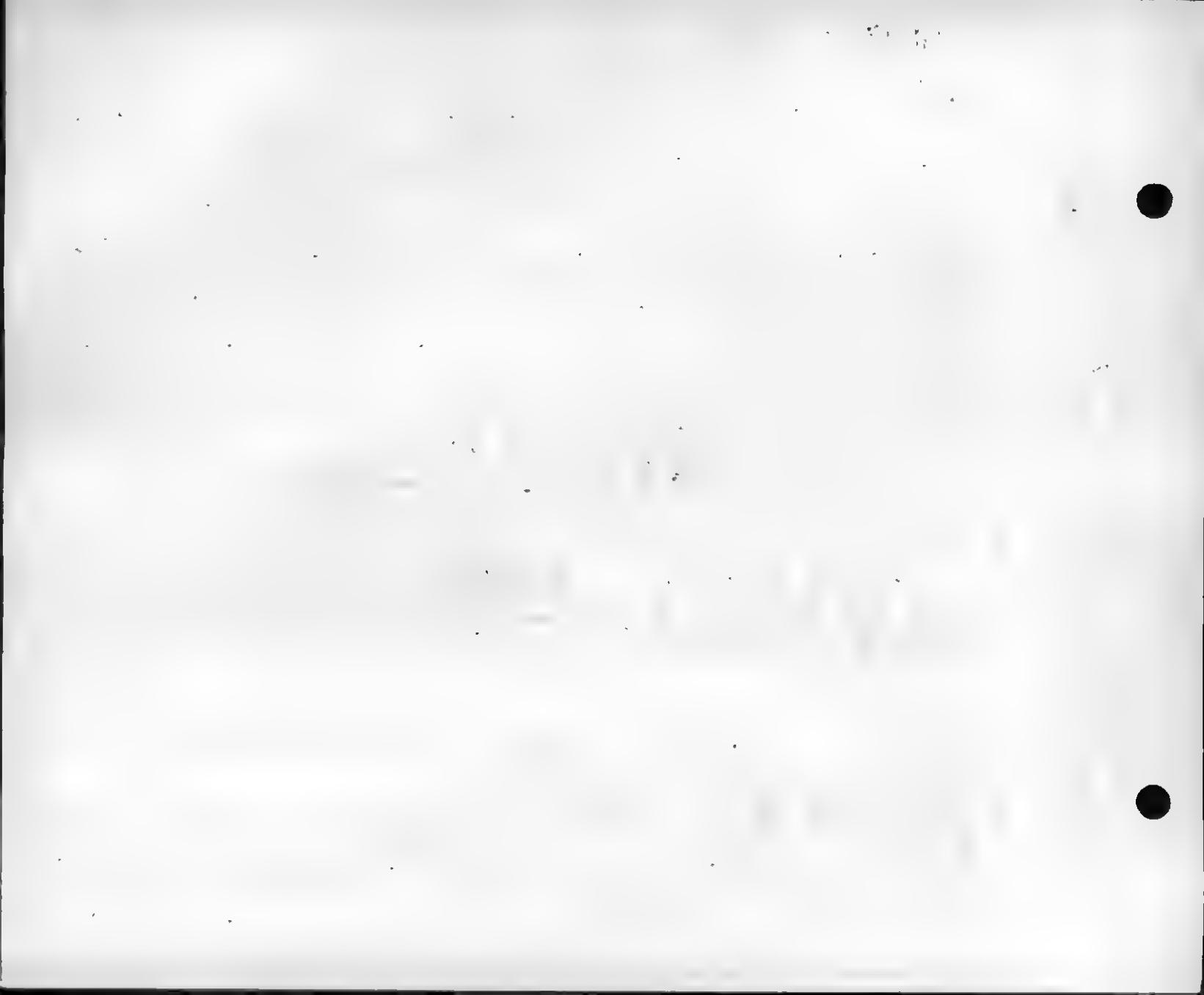
100 11

1 To HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

10 To FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper from pages 1 and 2, and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

1. DECEASED NAME (Type or print)	First  Doris	Middle  Erickson	Lost	20. DATE OF DEATH Month 11 Day 19 Year 68	26. HOUR 9:50aM
3. SEX  Female	4 RACE  White	S. DATE OF BIRTH  5-14-07	6. AGE (In years lost birthday) 60 YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. IF UNDER 24 HRS.	
7a. BIRTHPLACE (State or foreign country)  Maryland	7b. CITIZEN OF WHAT COUNTRY?  USA	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> SEP. <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. COUNTY OF DEATH  Prince George	Md	
10. CITY OR TOWN OF DEATH  Riverdale	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)  Eugene Leland Memorial	12a. USUA. OCCUPATION (Kind of work done during most of working life, even if retired)  Housewife	12b. KIND OF BUSINESS OR INDUSTRY  Name		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland	13b. COUNTY Pr. Geo.	13c. CITY OR TOWN Laurel	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 312 Main St.	
14. FATHER'S NAME First George	Middle V.	Lost Ward	15. MOTHER'S MAIDEN NAME Jessie	Middle G.	Last Hopper
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown no	16b. SOCIAL SECURITY NO.	17. INFORMANT Hospital records	Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory failure DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. Subdural Hematoma, right (b) Subdural Hematoma, right DUE TO, OR AS A CONSEQUENCE OF (c)					
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Central confusion, alcoholism					
19a. DATE OF OPERATION 11/17/68	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Subdural Hematoma	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from Nov. 17, 1968 to Nov. 19, 1968, that (I) (we) last saw the deceased alive on Nov. 19, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Jalazan E. Perez, M.D.	DEGREE PHYS.	ATTENDING MED. DIRECTOR <input checked="" type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	22c. DATE SIGNED Nov. 19, 1968	
22d. PHYSICIAN'S NAME (Type) B. E. Perez, M.D.	22e. ADDRESS 10305 Folk, Silver Spring, Montgomery, Md.				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 11-21-68	23c. NAME OF CEMETERY OR CREMATORIAL Meadowridge Mem Cemetery	23d. LOCATION (City or Town) Md	(County)	(State)
24. FUNERAL DIRECTOR Nameless Funeral Home, Laurel	ADDRESS ADDRESS	25a. REC'D BY REGISTRAR NOV 26 1968	25b. REGISTRAR'S SIGNATURE Charles Judge		



FOR STATE  
HEALTH DEPT.Item 18 Film 409 1-29 MARYLAND STATE DEPARTMENT OF HEALTH  
16327 DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if necessary. Please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3 Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Health Dept. prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 DECEASED NAME (Type or Print)		First	Middle	Last	2a DATE KNOWN OF ESTI- DEATH MATED <input checked="" type="checkbox"/>	Month	Day	Year	2b HO.HR
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (in years at birthday)	7 IF UNDER 1 YEAR MONTHS      DAYS	8 IF UNDER 24 HRS HOURS      MN	11-8-68 19 11 :00am			
Female	White	5-28-1911	57 yrs			2d HOUR			
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		B MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	9. COUNTY OF DEATH Prince George's Md.				
10 CITY OR TOWN OF DEATH Cheverly		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Prince George Hospital			12a J.S.CAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife			12b KIND OF BUSINESS OR INDUSTRY own home	
13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission and STATE Maryland)		13c CITY OR TOWN Prince George's		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER 2215 University Blvd.			
14 FATHER'S NAME First George		Middle W.	Last Gordon	15 MOTHER'S MAIDEN NAME First Mabel		Middle W.	Last Perkins		
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) No		16b SOCIAL SECURITY NO 578-05-8426		17. INFORMANT Mrs. Mabel W. Gordon 1011 Tracy Drive		ADDRESS Sil. Spr. Ma.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Congestive heart failure DUE TO, OR AS A CONSEQUENCE OF Arteriosclerotic heart disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) DUE TO, OR AS A CONSEQUENCE OF (c)									
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 4200 Inactive pulmonary tuberculosis									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
21a. EXTERNA. CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month Day, Year HOUR A.M. P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No.		City or Town	County	State	
22a I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE <i>John Kehoe</i>				CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22b DATE SIGNED 11-11-68	
EXAMINER'S NAME (Type)		John Kehoe MD Riverdale, Md.		ADDRESS (Street, City, town, or county) Suitland Dr. Ga. Maryland					
23a BURIAL, CREMATION, REMOVAL (Specify)		23b DATE 11-13-1968		23c NAME OF CEMETERY OR CREMATORIAL Cedar Hill Cemetery		23d LOCATION (City or Town) (County) (State) Suitland Dr. Ga. Maryland			
24 FUNERAL DIRECTOR Warner E. Purphrey, Inc.		24 ADDRESS J.W. Lee Sil. Spr. Md.		25a REC'D BY REGISTRAR NOV 14 1968		25b REGISTRAR'S SIGNATURE Charles Judge			



FOR STATE  
HEALTH DEPT.

Items 18&22a Film 407 MARYLAND STATE DEPARTMENT OF HEALTH  
12-2-68 a.m.s DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16340

16323

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 DECEASED NAME (Type or Print)		First	Middle	Lost	2a DATE KNOWN OF DEATH MATED	Month	Day	Year	2b HOUR		
		Onard			<input checked="" type="checkbox"/>	11-2-68	19?		M		
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (In years last birthday)	7 Fields	IF UNDER 1 YEAR	IF UNDER 24 HRS					
Male	White	12-27-1926	41	YRS	MONTHS	DAYS	HOURS	MIN.			
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?	8	MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	9 COUNTY OF DEATH				2c. DATE PRONOUNCED DEAD	2d HOUR	
Kentucky		U S A			Prince George's				Month Day Year	68 19 2:14pm M	
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)				12b KIND OF BUSINESS OR INDUSTRY		
Cheverly		Prince George Hospital			Repairman				Wax museum		
13a USUAL RESIDENCE (Where deceased resided, if institution. Residence before admission) STATE		13c CITY OR TOWN			13d INSIDE CITY LIMITS?		13e STREET AND NUMBER				
Maryland		Prince George's Capitol Hgts.			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		836 57th. Avenue			Md	
14. FATHER'S NAME		First	Middle	Lost	15 MOTHER'S MAIDEN NAME				First	Middle	
		Arnold	Fields		Zettie Sullivan						
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		(If yes give rank or dates of service)		16b SOCIAL SECURITY NO	17 INFORMANT				ADDRESS		
yes		W W II		405 22 1992	Joyce O'Neal				Forestville, Md.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart failure											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
4129 Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause lost											4-1-68
(b) Severe coronary arteriosclerosis											Unknown
DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF (c)											
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)											
19a DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?									20. AUTOPSY?
											YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b TIME OF INJURY Month, Day, Year HOUR A.M. P.M.		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)							
		19									
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f LOCATION Street or R.F.D. No		City or Town		County		State	
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE		<i>John Kehoe</i>									
EXAMINER'S NAME (Type)		John Kehoe MD Riverdale, Md.									
CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22b. DATE SIGNED					
						11-4-68					
23a BURIAL, CREMATION, REMOVAL(SORT OF)		23b DATE Nov 7, 1968		23c NAME OF CEMETERY OR CREMATORIUM Mountain View Memorial		23d LOCATION (City or Town) Colburn		(County)		(State)	
Burial								Kentucky			
24. FUNERAL DIRECTOR		ADDRESS		25a REC'D BY REGISTRAR		25b REGISTRAR'S SIGNATURE					
F. Gasch's Sons		Hyattsville, Md.				DATE NOV 7 1968				<i>Charles Judge</i>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 shall be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16343

CERTIFICATE OF DEATH

**10 HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.  
**10 FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician or attending physician  
 director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper  
 and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

1 DECEASED NAME (Type or print)		First <i>Charles</i>	Middle	Lost <i>Ford</i>	2d DATE OF DEATH Month Day Year <i>11 Month 3 Day 68 Year</i>	2b HOUR <i>1:35 PM</i>		
3 SEX <i>Male</i>	4 RACE <i>White</i>	5 DATE OF BIRTH <i>6/20/1883</i>		6 AGE (In years last birthday) <i>85</i> YRS.	IF UNDER 1 YEAR MONTHS <i>0</i>	IF UNDER 24 HRS DAYS <i>0</i>	2b HOUR HOURS <i>1</i>	2b HOUR MIN <i>34</i>
7a BIRTHPLACE (State or foreign country) <i>Md</i>	7b CITIZEN OF WHAT COUNTRY? <i>USA</i>	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED	9. COUNTY OF DEATH <i>Prince George</i>		Md			
10 CITY OR TOWN OF DEATH <i>Hyattsville, Md</i>	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Madison Manor Nursing Home 3801 42nd Ave</i>		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>Pressman</i>	12b KIND OF BUSINESS OR INDUSTRY <i>U S Govt.</i>				
13a USUAL RESIDENCE (Where deceased lived, if institution: Res dente before admission) STATE <i>Md</i>	13b COUNTY <i>Pro George's</i>	13c CITY OR TOWN <i>Riverdale</i>	13d INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	13e STREET AND NUMBER <i>6209 57th ave.</i>				
14. FATHER'S NAME First <i>John Ford</i>	Middle	Lost	15. MOTHER'S MAIDEN NAME First <i>Anna Gumpf</i>	Middle	Last			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <i>No</i>	16b SOCIAL SECURITY NO <i>214533156</i>	17 INFORMANT <i>John B Ford</i>	Address <i>Riverdale, Md.</i>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <i>1538</i>		DUE TO, OR AS A CONSEQUENCE OF <i>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause</i> (b) <i>Carcinoma of Colon</i> (c) <i>Carcinoma of Colon</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>14 years</i> <i>6 years</i>				
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>1538</i>								
19a. DATE OF OPERATION <i>1538</i>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 1b.)					
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>		21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY OFFICE BUILDING, ETC)	21f LOCATION Street or R.F.D. No	City or Town	County	State		
22a. I certify that (I) (this hospital) attended the deceased from _____, 1967, to 1968, that (I) (we) last saw the deceased alive on 10-31-1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE <i>DONALD C. EDGREN</i>		DEGREE <i>MD</i>	ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS	22c DATE SIGNED <i>11-4-68</i>				
22d. PHYSICIAN'S NAME (Type) <i>DONALD C. EDGREN</i>		22e ADDRESS <i>3509 East-West Highway Hyattsville, Md.</i>						
23a. BURIAL, CREMATON, REMOVAL (Specify) <i>Burial</i>		23b DATE <i>Nov 6, 1968</i>	23c NAME OF CEMETERY OR CREMATORIUM <i>Ft Lincoln Cemetery</i>	23d LOCAT.ON (City or Town) <i>Colmar Manor Pro Geo</i>	(County) <i>Md</i>	(State)		
24. FUNERAL DIRECTOR <i>F. Gasch's Sons</i>		ADDRESS <i>Hyattsville Md.</i>	25a. REC'D. BY REGISTRAR DATE <i>NOV 7 1968</i>	25b REGISTRAR'S SIGNATURE <i>Charles Judge</i>				



MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
CERTIFICATE OF DEATH

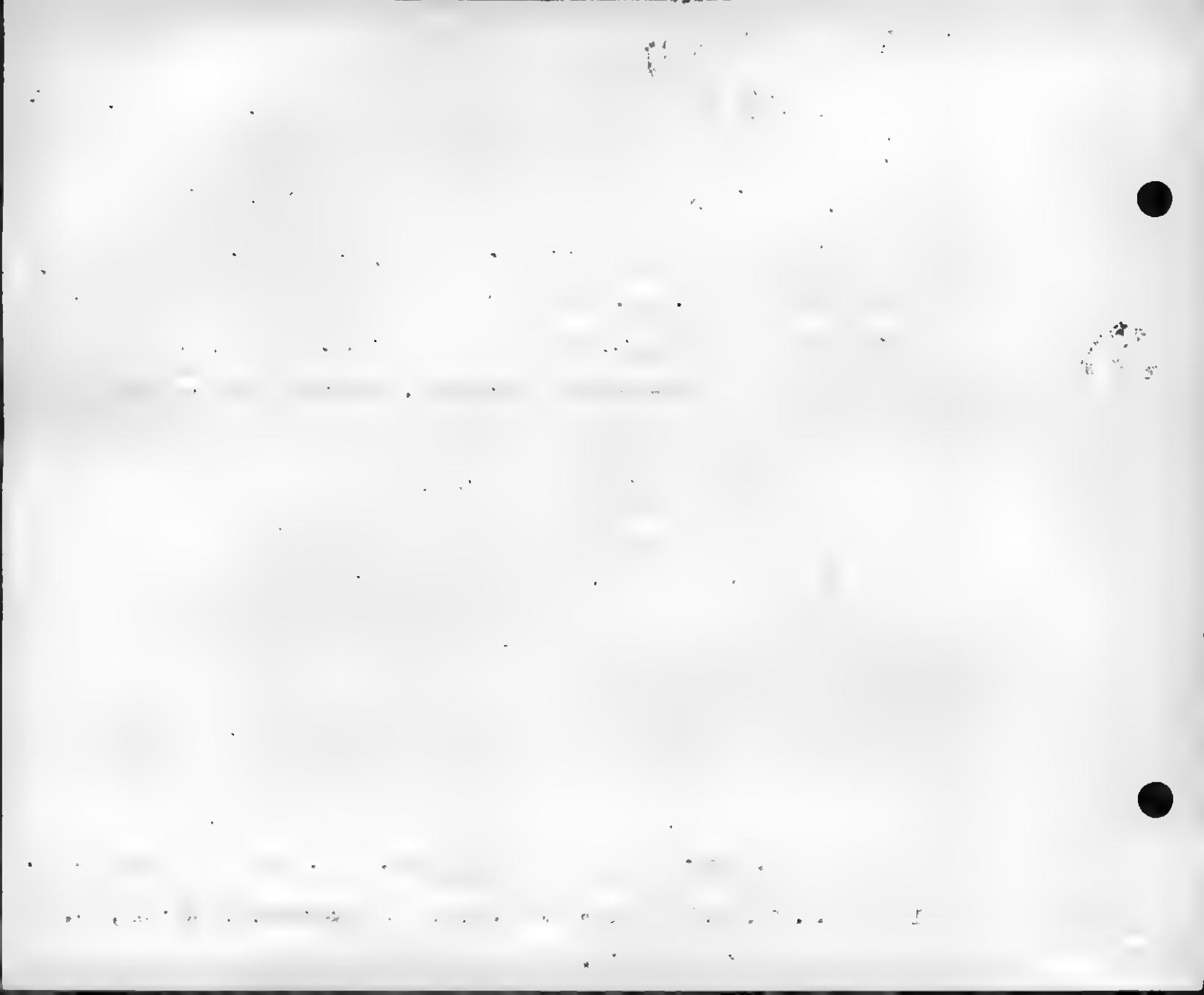
16330

1631

**10 HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

**10 FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print)		First <i>Louis.</i>	Middle <i>S.</i>	Last <i>FORSYTHE</i>	20. DATE OF DEATH Month <i>11</i>	Day <i>20</i>	Year <i>68</i>	2b. HOUR <i>3:50 PM</i>
3. SEX <i>MALE</i>	4. RACE <i>White</i>	5. DATE OF BIRTH <i>10-30-95</i>			6. AGE (In years last birthday) <i>73 YRS</i>	IF UNDER 1 YEAR MONTHS <i>0</i>		IF UNDER 24 HRS. HOURS <i>0</i>
7a. BIRTHPLACE (State or foreign country) <i>North Carolina</i>	7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH <i>Prince Geo.</i>			
10. CITY OR TOWN OF DEATH <i>College Park - Md.</i>	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Greenbelt Conv. Center</i>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>Book Binder</i>			12b. KIND OF BUSINESS OR INDUSTRY <i>Print Co.</i>	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Maryland</i>	13b. COUNTY <i>Pr. Geo.</i>	13c. CITY OR TOWN <i>Greenbelt</i>	13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	13e. STREET AND NUMBER <i>8 B Anthony Greenbelt Md.</i>				
14. FATHER'S NAME <i>Cedared E. Forsythe</i>	First	Middle	Last	15. MOTHER'S MAIDEN NAME <i>Caroline Collins</i>	First	Middle	Last	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, No, or Unknown <i>No</i>	16b. SOCIAL SECURITY NO. <i>229-10-8627</i>			17. INFORMANT <i>Margaret H. Forsythe - Same as # 13</i>	Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>41.</i> DUE TO, OR AS A CONSEQUENCE-OF Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause <i>Arteriosclerosis. Cardiac failure</i>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>9 days.</i>			
(b) DUE TO, OR AS A CONSEQUENCE-OF Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause <i>Arteriosclerosis generally.</i>								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>Complete heart block with underlying disease.</i>								
19a. MEDICAL CERTIFICATION	19b. DATE OF OPERATION	19c. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) <i>At home, Farm, Street, Factory, Office Building, etc.</i>			21d. LOCATION Street or R.F.D. No.	City or Town	County	State
21e. PLACE OF INJURY While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>				21f.				
22a. I certify that (I) (this hospital) attended the deceased from <i>Oct 1968</i> , 1968, to <i>Nov 20, 1968</i> , that (I) (we) last saw the deceased alive on <i>Nov 19, 1968</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE <i>Norman P. Fogarty</i>	DEGREE ATTENDING PHYS	<input type="checkbox"/>	MED. DIRECTOR	<input type="checkbox"/>	STAFF PHYS.	<input type="checkbox"/>	22c. DATE SIGNED <i>11/20/68</i>	
22d. PHYSICIAN'S NAME (Type) <i>Norman P. Fogarty</i>	22e. ADDRESS <i>820-Univ. Blvd. East, Silver Spring, Md.</i>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE <i>Nov. 22, 1968</i>	23c. NAME OF CEMETERY OR CREMATORIUM <i>Olive Branch Cemetery</i>			23d. LOCATION (City or Town) <i>Portsmouth</i>	(County) <i>Norfolk</i>	(State) <i>Va.</i>	
24. FUNERAL DIRECTOR <i>F. Gasch's Sons</i>	ADDRESS <i>Hyattsville, Md.</i>			25a. REC'D BY REGISTRAR <i>Charles J. ...</i>	25b. REGISTRAR'S SIGNATURE <i>Charles J. ...</i>			
				DATE <i>Nov 21 1968</i>				



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

16331

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10340

1. DECEASED NAME (Type or Print)	First	Middle	Last	2a. DATE KNOWN <input type="checkbox"/> Month Day Year OF ESTI- DEATH MATED <input checked="" type="checkbox"/> 11-13-68 9 6:00am	2b. HOUR 2d. HOJR	
Walnut			Fox			
3. SEX Male	4. RACE White	5. DATE OF BIRTH 11-16-1906	6. AGE (in years last birthday) 63 yrs	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN 11 13 68 19		
7a. BIRTHPLACE (State or foreign country) VIRGINIA	7b. CITIZEN OF WHAT COUNTRY? U.S.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Prince George's Md.			
10. CITY OR TOWN OF DEATH Riverdale	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Chamber's Funeral Home			12a. OCCUPATION (Kind of work done during most of working life, even if retired.) INSERTED	12b. KIND OF BUSINESS OR INDUSTRY Post News Paper	
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE, Maryland	13b. COUNTY Prince George's Hillsides	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 5111 Marlboro Pike		
14. FATHER'S NAME UNKNOWN	First	Middle	Last	15. MOTHER'S MAIDEN NAME UNKNOWN		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) YES	16b. SOCIAL SECURITY NO. Kew. II 22 621 62384	17. INFORMANT MILITARY RECORDS	ADDRESS		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 5th. degree burns of 100 % of body surface DUE TO, OR AS A CONSEQUENCE OF 70X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(o) 11-13-68						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
MEDICAL CERTIFICATION		21b. TIME OF INJURY Month, Day, Year HOUR A.M. PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH 5:43am 11-13-1968	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) Trapped in house fire.			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	21e. PLACE OF INJURY (At home, farm, street factory, office building, etc.) home	21f. LOCATION Street or R.F.D. No same as #13	City or Town	County	State	
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>						
ACTUAL SIGNATURE <i>John Kehoe</i>	CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ADDRESS (Street, city, town, or county) John Kehoe MD Riverdale, Md.			22b. DATE SIGNED 11-14-68		
23a. BURIAL, CREMATION REMOVAL (Specify) BURIAL	23b. DATE 11-20-1968	23c. NAME OF CEMETERY OR CREMATORIAL BALTIMORE NAT'L CEM	23d. LOCATION (City or Town) BALTIMORE, MD.	(County)	(State)	
24. FUNERAL DIRECTOR W.W. CHAMBERS	ADDRESS C. RIVERDALE, MD.	25a. REC'D BY REGISTRAR DATE NOV 25 1968	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1 and 2 with the State Department of Health to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 74-3, which may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-tombstone permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

ITEM 18 & 22a Film 407 MARYLAND STATE DEPARTMENT OF HEALTH  
1-26-60ams DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16332

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

16332

1 DECEASED NAME (Type or Print)	First	Middle	Last	2a DATE KNOWN OF ESTI. DEATH MATED <input checked="" type="checkbox"/> 11-3-68 195:00amm	Month Day Year	2b HOUR		
Elizabeth	Louise	Gallagher						
3 SEX Female	4. RACE White	5 DATE OF BIRTH 3-3-1921	6 AGE (in years last birthday) 47 yrs.	7 IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	8 IF UNDER 24 HRS MONTHS DAYS HOURS MIN	2c DATE PRONONCED DEAD Month Day Year 11 3 68 198:32am M		
7a BIRTHPLACE (State or foreign country) Pa	7b CITIZEN OF WHAT COUNTRY? U.S.A.	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Prince George's Md.					
10. CITY OR TOWN OF DEATH Cheverly		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Prince George Hospital		12a USUAL OCCUPATION (Kind of work done during most of work no life, even if retired.) Housewife		12b KIND OF BUSINESS OR INDUSTRY home		
13a U.S.A. RESIDENCE (Where deceased admission) STATE Maryland		13b COUNTY Prince George's		13c CITY OR TOWN Bowie	13d INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	13e STREET AND NUMBER 12510 Millstream Drive		
14 FATHER'S NAME William Mc Nulty		15 MOTHER'S MAIDEN NAME Mary Nash						
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no	16b SOCIAL SECURITY NO (If yes give war or dates of service) 168 12 8766	17. INFORMANT Edward P Gallagher	ADDRESS Bowie, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)  Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last				Heart failure		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH M1		
(b) Arteriosclerotic heart disease						Unk		
DUE TO, OR AS A CONSEQUENCE OF (c)								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 4-4-68								
19a. DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)				
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f LOCATION Street or R.F.D. No		City or Town	County	State
22a I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>								
ACTUAL SIGNATURE <i>John Kehoe</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> MD ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ADDRESS (Street, city, town, or county) John Kehoe MD Riverdale, Md.				22b DATE SIGNED 11-4-68		
23a BURIAL, CREMATION, REMOVAL (Specify) Burial		23b DATE Nov 6, 1968		23c NAME OF CEMETERY OR CREMATORY Arlington National		23d LOCATION (City or Town) (County) (State) Arlington Arlington Va		
24. FUNERAL DIRECTOR		ADDRESS F. Gasch's Sons Hyattsville, Md.		25a. REC'D BY REGISTRAR DATE NOV 7 1968		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		



**HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

**FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1, 2, 3 and 4 may be retained by the hospital or attending physician.

Item 4 Film GL 07 12 / 3 / 68 kk MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201												16332	CERTIFICATE OF DEATH			10347
1. DECEASED NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH			2b. HOUR							
Shoosan			E.	Ghazarian		Month Day Year			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.							
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (In years last birthday) 66 yrs.							
Female			Caucasian			4/5/1902			IF UNDER 24 HRS							
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH							
Tabriz, Iran			Iran						Prince Georges							
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY							
Riverdale			E. Leland Memorial			Housewife										
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. CITY OR TOWN COUNTY			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			13e. STREET AND NUMBER							
Md.			P.G.			Brentwood			4520 - 30th St.							
14. FATHER'S NAME			First	Middle	Last	15. MOTHER'S MAIDEN NAME			First	Middle	Last					
Phytohly Baghdasar Acopian						Unknown			Marian		Unknown					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown)			16b. SOCIAL SECURITY NO			17. INFORMANT			Address (above address)							
No						Ivan Luka										
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute Pulmonary Edema</i> APPROXIMATE INTERVAL DUE TO, OR AS A CONSEQUENCE OF 6 day Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) <i>Renal Failure</i> 5 day lost DUE TO, OR AS A CONSEQUENCE OF 6 day (c) <i>Thrombosis</i>																
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																
MEDICAL CERTIFICATION		19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?						
								YES <input type="checkbox"/> NO <input type="checkbox"/>								
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)											
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)			21f. LOCATION Street or R.F.D. No.			City or Town		County	State					
22a. I certify that (I) (this hospital) attended the deceased from 11-8-68 to 11-15-68, that (I) (we) last saw the deceased alive on 11-8-68, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																
22b. SIGNATURE <i>Shanass</i>																
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS			22f. DATE SIGNED											
OHHANNES SAHAKYAN		6001 Landover Rd Cheverly MD														
23a. BURIAL, CREMATION, REMOVAL, ETC.		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL Pleasant Cem.			23d. LOCATION (City or Town)		(County)	(State)						
Burial		11/19/68		Mt. Pleasant Cem.			Arlington, Mass.									
24. FUNERAL DIRECTOR		ADDRESS			Mt. Rainier Md.			25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE						
Home		Nalley's Funeral						DATE Nov 25 1968		Charles Judge						
VR A15 (4) 30M REV. 1/68																



**10 HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate

Page 4 may be retained by the hospital or attending physician.

**10 FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

I executed within 24 hours after death.

**MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201**

Item 1, Film 3400 1/13/69 enc **CERTIFICATE OF DEATH****16348**

1. DECEASED NAME (Type or print)		First	Middle	Last	2a DATE OF DEATH Month	Year	2b HOUR P.M.
Baby/Boy		John	Ernest	Gibbs	Nov.	16	10:00
3. SEX Male		4. RACE Cauc.		5. DATE OF BIRTH 11-16-68	6. AGE (In years last birthday) — yrs.		7. IF UNDERR 1 YEAR MONTHS DAYS HOURS MIN
7a BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Prince Georges		Md.
10. CITY OR TOWN OF DEATH Cheverly		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Prince Georges Gen. Hosp.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.		13c. CITY OR TOWN Edgewater		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER Rt. 3, Box 686	
14. FATHER'S NAME William		First	Middle	Last	15. MOTHER'S MAIDEN NAME Mary	First	Middle
					Elizabeth	Burdette	Last
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown)		16b. SOCIAL SECURITY NO.		17. INFORMANT		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)  1740		DUE TO, OR AS A CONSEQUENCE OF (b) Rh incompatibility.				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
Conditions if any, which gave rise to immediate cause (a), stating the underlying cause last		DUE TO, OR AS A CONSEQUENCE OF (c)					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.	City or Town	County	State
22a. I certify that (I) (checkmark) attended the deceased from Nov. 16, 1968, to Nov. 16, 1968, that (I) (checkmark) last saw the deceased alive on Nov. 16, 1968, and that in (my) (checkmark) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (checkmark) (did not) view the body after death.							
22b. SIGNATURE H. E. Altman		DEGREE ATTENDING PHYS.	MED DIRECTOR	STAFF PHYS.	22c. DATE SIGNED 11/17/68		
22d. PHYSICIAN'S NAME (Type) Harry E. Altman, M. D.		22e. ADDRESS 2025 Eye Street, N. W., Wash., DC 20006					
23a. BURIAL, CREMATION REMOVAL (Select)		23b. DATE 11/23/68		23c. NAME OF CEMETERY OR CREMATORIAL Prince Geo. General Hosp.		23d. LOCATION (City or Town) (County) (State) Cheverly, Maryland	
24. FUNERAL DIRECTOR HARRY W. PENN, JR., ADMINISTRATOR		ADDRESS		25a. REC'D BY REGISTRAR NOV 29 1968		25b. REGISTRAR'S SIGNATURE Charles Judge	
VR A15 30M REV. 1							



MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

16335

16335

**10 HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.  
 Page 4 may be retained by the hospital or attending physician.

**10 FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please return carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation or removal and if any event within 72 hours after death, this certifies that Dr. Keego, Medical Examiner of Prince George's County notified and approved.

1. DECEASED-NAME (Type or print)		First <b>MARIA (Mary) NM</b>	Middle	Last <b>GILBERT</b>	2a. DATE OF DEATH Month <b>November</b>	2b. HOUR Day <b>27, 1968</b>	2b. HOUR Year <b>3:20 P.M.</b>	
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH <b>July 16, 1919</b>	6 AGE (In years last birthday) <b>49</b>		IF UNDER 1 YEAR MONTHS <b>YRS.</b>	IF UNDER 24 HRS MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (State or foreign country) <b>Penn.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/>	DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH <b>Prince George</b>	
10 CITY OR TOWN OF DEATH <b>Camp Springs</b>		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Andrew's Air Force Base</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>Sales Clerk</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Sales</b>	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Penn.</b>		13c. CITY OR TOWN <b>Lackawanna</b>		13d. INSIDE CITY LIMIT? <b>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></b>	13e. STREET AND NUMBER <b>1407 Dorothy Street</b>			
14. FATHER'S NAME First <b>William</b>		Middle <b>D'Amico</b>	Lost	15. MOTHER'S MAIDEN NAME First <b>unknown</b>		Middle	Lost	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <b>No</b>		16b. SOCIAL SECURITY NO. <b>202-42-4032</b>		17 INFORMANT <b>Mr. Daniel N. Gilbert same as above</b>		Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>RESPIRATORY &amp; VASCULAR QOL 44 PS 13</b> <b>3474</b> DUE TO, OR AS A CONSEQUENCE OF Conditions if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>BRANN ST 11 17 AM 40 E</b> DUE TO, OR AS A CONSEQUENCE OF (c)								
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
					YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, not by medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No	City or Town	County	State	
22a. I certify that (I) (this hospital) attended the deceased from <b>27 Nov. 1968</b> , to <b>27 Nov. 1968</b> that (I) (we) last saw the deceased alive on <b>27 Nov. 1968</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE <b>Arvin Arthur M.D.</b>		DEGREE <b>M.D.</b>	ATTENDING PHYS. <input type="checkbox"/>	MED DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input checked="" type="checkbox"/>	22c. DATE SIGNED <b>27 Nov 68</b>		
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS <b>Andrew's Air Force Base Camp Spr., Md.</b>						
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>11-30-68</b>	23c. NAME OF CEMETERY OR CREMATORIAL <b>Cathedral Cemetery</b>		23d. LOCATION (City or Town) <b>Scranton Lackawanna Penna.</b>		(County) (State)	
24. FUNERAL DIRECTOR <b>M. Andrew D. Duvall</b>		ADDRESS <b>M. G. Duvall</b>		25e. REC'D BY REGISTRAR DATE <b>DEC 3 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		
VR A15 30M REV. 1/68		Warner E. Pumphrey Inc. 8434 Ga. Ave. S.S., Md.						



**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

**Page 4 may be retained by the hospital or attending physician.**  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 and 4 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

**CERTIFICATE OF DEATH**

1 DECEASED NAME (Type or print)	First Florence	Middle E	Last Goette	2a. DATE OF DEATH Month November	Day 23	Year 1968	2b. HOUR 4:35 M
3. SEX Female	4. RACE White	5. DATE OF BIRTH September 26, 1881		6. AGE (in years last birthday) 87 YRS		7. UNDERR 1 YEAR MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (State or foreign country) Canada	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Prince George		Md.		
10. CITY OR TOWN OF DEATH Hyattsville	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Sacred Heart Home		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Housewife		12b. KIND OF BUSINESS OR INDUSTRY home		
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE Maryland	13b. COUNTY Prince George	13c. CITY OR TOWN Laurel	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 8618 Kiama Road			
14. FATHER'S NAME First George	Middle Knox	15. MOTHER'S MAIDEN NAME First Mary			Middle Last Brogan		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown	16b. SOCIAL SECURITY NO.	17. INFORMANT Sacred Heart Home, Hyattsville, Maryland			Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CORONARY THROMBOSIS c MYOCARDIAL INFARCTION</u>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 days			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerosis Heart DISEASE</u> DUE TO, OR AS A CONSEQUENCE OF				3 years			
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)							
4 MEDICAL CERTIFICATION		19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
		21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b.)			
		21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. _____ City or Town _____ County _____ State _____			
22a. I certify that (I) (this hospital) attended the deceased from <u>11-23</u> , 19 <u>68</u> , to <u>11-23</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>11-23</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>Thomas F Collins M.D.</i>		DEGREE ATTENDING PHYS.	<input type="checkbox"/> MED DIRECTOR	<input checked="" type="checkbox"/> STAFF PHYS	22c. DATE SIGNED <u>11-23-68</u>		
22d. PHYSICIAN'S NAME (Type) THOMAS F COLLINS		22e. ADDRESS <u>322- H/21 NE</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 11/26/68	23c. NAME OF CEMETERY OR CREMATORIAL Catholic Cemetery	23d. LOCATION (City or Town) (County) (State) Savannah, Georgia				
24. FUNERAL DIRECTOR <i>Donaldson J.H.</i>	ADDRESS <i>Laurel Md.</i>	25a. REC'D BY REGISTRAR DATE NOV 29 1968	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>				
VR A15 (4) 30M REV. 1/68							



MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
CERTIFICATE OF DEATH

16337

16351

**10 HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.  
**Page 4** may be retained by the hospital or attending physician.  
**10 FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1, 2, and 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 DECEASED-NAME (Type or print)		First <b>Jessie</b>	Middle <b>B.</b>	Last <b>Graham</b>	2a DATE OF DEATH Month <b>11</b>	Day <b>23</b>	Year <b>1968</b>	2b HOUR <b>11:40PM</b>	
3. SEX <b>Female</b>		4. RACE <b>Negro</b>		S DATE OF BIRTH <b>11/27/1898</b>	6 AGE (In years last b'day) <b>69</b> YRS.		IF UNDER 1 YEAR MONTHS <b>0</b>	IF UNDER 24 HRS. HOURS <b>0</b>	MIN <b>0</b>
7a BIRTHPLACE (State or foreign country) <b>S. C.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH <b>Prince Georges</b>				
10 CITY OR TOWN OF DEATH <b>Glenn Dale</b>		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Glenn Dale Hospital</b>		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>unknown - retired</b>		12b KIND OF BUSINESS OR INDUSTRY <b>unknown</b>			
13a USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE <b>Wash., D.C.</b>		13c CITY OR TOWN <b>Wash., D.C.</b>		13d INSIDE CITY LIMIT? <b>YES</b> <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e STREET AND NUMBER <b>1432 R St., N. W.</b>				
14. FATHER'S NAME First <b>Unknown</b>		Middle <b></b>	Last <b></b>	15 MOTHER'S MAIDEN NAME First <b>Ada Mobley</b>		Middle <b></b>	Last <b></b>		
16a WAS DECEASED EVER IN U.S. ARMED FORCES? <b>No</b> (Yes, no, or unknown) (If yes give war or dates of service)		16b SOCIAL SECURITY NO <b>unknown</b>		17 INFORMANT <b>Decedent</b>		Address			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Congestive heart failure</b> <b>4120</b>		DUE TO, OR AS A CONSEQUENCE OF (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause <b>Hypertensive and arteriosclerotic cardiovascular disease</b>		DUE TO, OR AS A CONSEQUENCE OF (c) <b>Diabetes mellitus with diabetic nephrosclerosis</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>4 days</b>			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE FATAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b></b>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>Yes</b>				
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. <b>10</b> Month <b>10</b> Day <b>18</b> Year <b>1968</b>	21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18) <b>While at work</b>						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY OFFICE BUILDING, ETC.) <b>Arlington</b>	21f. LOCATION Street or R.F.D. No <b>Glenn Dale Hospital</b>	City or Town <b>Glenn Dale, Maryland</b>	County <b>Prince Georges</b>	State <b>MD</b>			
22a. I certify that <b>(he)</b> (this hospital) attended the deceased from <b>10/18/1968</b> , to <b>11/23/1968</b> , that <b>(we)</b> last saw the deceased alive on <b>11/23/1968</b> , and that in <b>(our)</b> (our) opinion death occurred on the date and hour and from the causes stated above, <b>(we)</b> (did) <b>(did not)</b> view the body after death.		22b. SIGNATURE <b>Moe Weiss</b>		DEGREE <b>PHYS</b>	ATTENDING PHYS <input type="checkbox"/>	MED DIRECTOR <input checked="" type="checkbox"/>	STAFF PHYS <input type="checkbox"/>	22c DATE SIGNED <b>11/23/68</b>	
22d PHYSICIAN'S NAME (Type) <b>Moe Weiss, M. D.</b>		22e. ADDRESS <b>Glenn Dale Hospital Glenn Dale, Maryland</b>							
23a BURIAL, CREMATION, REMAINTLED (Specify) <b>Remainder</b>		23b. DATE <b>11/29/1968</b>	23c NAME OF CEMETERY OR CREMATORIAL <b>Arlington</b>		23d. LOCATION (City or Town) <b>Arlington</b>		(County) <b>Prince Georges</b>	(State) <b>MD</b>	
24. FUNERAL DIRECTOR <b>Ernest Jarvis Co., Inc.</b>		ADDRESS <b>1432 U St. N.W.</b>	25a. REC'D BY REGISTRAR <b>NOV 29 1968</b>		25b. REG STRR'S SIGNATURE <b>Charles Judge</b>				
VR A15 (4) 30M REV 1/68									



MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

16338

1635

**10 HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.  
**Page 4** may be retained by the hospital or attending physician.  
**10 FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transt permit. Then please remove carbon paper pages 1 and 2, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 DECEASED NAME (Type or print)		First <b>Leonard</b>	Middle <b>K.</b>	Lost <b>Grant</b>	2a DATE OF DEATH Nov. Month 28, Day 1968 Year	2b HOUR 7:25 P.M.	
3 SEX <b>Male</b>		4. RACE <b>Caucasian</b>		S. DATE OF BIRTH <b>Sept. 9, 1895</b>	6. AGE (In years last birthday) <b>75</b> YRS	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS HOURS MIN
7a. BIRTHPLACE (State or foreign country) <b>Maine</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH <b>Prince George's</b>		
10. CITY OR TOWN OF DEATH <b>Cheverly</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Prince Geo. Gen'l Hospital</b>		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>Bookbinder</b>		12b KIND OF BUSINESS OR INDUSTRY <b>Gov. Retired</b>	
13a USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) STATE <b>Maryland</b>		13b COUNTY <b>Prince George's</b>		CITY OR TOWN <b>Forest Hgts.</b>	13d INSIDE CITY LIMITS? <input type="checkbox"/> YES <input type="checkbox"/> NO	13e STREET AND NUMBER <b>315 Sachem Drive</b>	
14 FATHER'S NAME First <b>Fre</b>		Middle <b>Grant</b>	Last <b></b>	15 MOTHER'S MAIDEN NAME First <b>Lillie M. Reed</b>		Middle <b></b>	Last <b></b>
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown <b>No</b>		16b SOCIAL SECURITY NO. <b></b>		17 INFORMANT <b>Howard L. Grant</b>		Address <b>315 Sachem Dr. Forest Hgts</b>	
18 CAUSE OF DEATH (Enter on one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Broncho-pneumonia.</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2381 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, wh ch gave rise to immediate cause (a), stating the underlying cause last (b) <b>Brain Tumor (Pituitary gland).</b> DUE TO, OR AS A CONSEQUENCE OF (c)							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <input checked="" type="checkbox"/> Yes		
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY OFFICE BUILDING ETC)		21f LOCATION Street or R.F.D. No.	CITY or Town	County	State
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>Nov. 10, 1968</b> , to <b>Nov. 28, 1968</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>Nov. 28, 1968</b> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) did <input checked="" type="checkbox"/> view the body after death.							
22b. SIGNATURE <i>Arnold G. Brody</i>		DEGREE <b>M.D.</b>	ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input checked="" type="checkbox"/>	22c. DATE SIGNED <b>Nov. 28, 1968</b>	
22d. PHYSICIAN'S NAME (Type) <b>Arnold G. Brody, M. D.</b>		22e. ADDRESS <b>Prince Geo. Gen'l Hospital, Cheverly, Md.</b>					
23a. BURIAL/CREMATION REMOVAL <input checked="" type="checkbox"/> <input type="checkbox"/>		23b. DATE <b>Dec. 2, 1968</b>	23c. NAME OF CEMETERY OR CREMATORIUM <b>Cedar Hill Cemetery</b>	23d. LOCATION (City or Town) <b>Suitland Md.</b> (County) (State)			
24. FUNERAL DIRECTOR <b>Robert E. Wilhelm</b>		ADDRESS <b>4308 Suitland Rd. Suitland Md.</b>		25a. REC'D. BY REGISTRAR <b>DEC 3 1968</b>	25b. REGISTRAR'S SIGNATURE <i>James J. Judge</i>		



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if necessary; please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 101, page 5, may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1035

1. DECEASED NAME (Type or Print)		First Anne	Middle Fagan	Last Grau	2a DATE KNOWN OF ESTI. DEATH MATED <input checked="" type="checkbox"/> 11-7-68	Month 19 PM	Day M	Year	2b HOUR
3 SEX Female	4 RACE White	5 DATE OF BIRTH 7-24-1913	6. AGE (in years last birthday) 55 yrs	IF UNDER 1 YEAR MONTHS 8	IF UNDER 24 HRS. DAYS 8	HOURS 68	MIN 199		2d HOUR
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED WIDOWED <input type="checkbox"/>		9. COUNTY OF DEATH Prince George's			
10 CITY OR TOWN OF DEATH College Park		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 4604 Amhurst Drive				12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Princess George's College Park		12b KIND OF BUSINESS OR INDUSTRY	
13a USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE Maryland		13c CITY OR TOWN COUNTY Prince George's College Park		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET AND NUMBER 4604 Amhurst Drive			
14. FATHER'S NAME First		Middle	Last	15. MOTHER'S MAIDEN NAME First		Middle	Last		
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b SOCIAL SECURITY NO (If yes give war or dates of service)		17 INFORMANT		ADDRESS			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Asphyxiation							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost		DUE TO, OR AS A CONSEQUENCE OF Closed in refrigerator							
(b)		DUE TO, OR AS A CONSEQUENCE OF							
(c)									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 1748									
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED?		20 AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b TIME OF INJURY Month, Day, Year HOUR AM PM 11-7-68		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) self.					
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>		21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.) kitchen of home		21f LOCATION Street or R.F.D. No. City or Town same as # 13		County State			
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from. Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE <i>John Kehoe</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		22b. DATE SIGNED 11-9-68			
EXAMINER'S NAME (Type)		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		ADDRESS (Street, City, town, or county)					
23a BURIAL, CREMATION, REMOVAL (Specify)		23b DATE 11/12/68		23d LOCATION (City or Town) County State					
24 FUNERAL DIRECTOR Dept. of Anatomy, Johns Hopkins School of Med.		ADDRESS		25a REC'D BY REGISTRAR		25d REGISTRAR'S SIGNATURE <i>Charles Judge</i>			
24 FUNERAL DIRECTOR Dept. of Anatomy, Johns Hopkins School of Med.		ADDRESS		25a REC'D BY REGISTRAR		25d REGISTRAR'S SIGNATURE <i>Charles Judge</i>			
24 FUNERAL DIRECTOR Dept. of Anatomy, Johns Hopkins School of Med.		ADDRESS		25a REC'D BY REGISTRAR		25d REGISTRAR'S SIGNATURE <i>Charles Judge</i>			



**1** 10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.  
10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

16340

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

1635

File #407 12/3/68 km

## CERTIFICATE OF DEATH

1. DECEASED NAME (Type or print)	First <i>ELsie</i>	Middle	Last <i>GREENFIELD</i>	2d. DATE OF DEATH Month <i>NOVEMBER</i>	Year <i>1968</i>	2d. HOUR <i>5:30 P.M.</i>	
3. SEX <i>F</i>	4. RACE <i>C Negro</i>	S. DATE OF BIRTH <i>1-28-'94</i>	6. AGE (in years last birthday) <i>74 yrs</i>	IF UNDER 1 YEAR <i>9 M</i>	IF UNDER 24 HRS. MONTHS <i>9</i>	IF UNDER 24 HRS. DAYS <i>14</i>	
7a. BIRTHPLACE (State or foreign country) <i>Maryland</i>	7b. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED	9. COUNTY OF DEATH <i>PR. GEORGES</i>	Md.			
10. CITY OR TOWN OF DEATH <i>CLINTON MD</i>	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>PINEVIEW GARDENS HOME</i>	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>HOUSEWIFE</i>	12b. KIND OF BUSINESS OR INDUSTRY				
13a. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) STATE <i>MD</i>	13c. CITY OR TOWN <i>Waldorf</i>	13d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	13e. STREET AND NUMBER <i>Rt. 3 Box 456</i>				
14. FATHER'S NAME First <i>John</i>	Middle <i>HENRY</i>	Last <i>GREENFIELD</i>	15. MOTHER'S MAIDEN NAME First <i>JANE</i>	Middle	Last <i>ALBERTA</i>	Address <i>Washington</i>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <i>Yes</i>	16b. SOCIAL SECURITY NO. <i>211-216-14</i>	17. INFORMANT <i>MRS. ERNEST MARSHALL</i>	APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>431.0 Circulatory Collapse.</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <i>Cerebral Hemorrhage</i> (b) <i>DUE TO, OR AS A CONSEQUENCE OF</i> (c) <i>Atherosclerotic Hypertension Disease</i>							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>Rt. Hemiplegia Diabetes Mellitus</i>							
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death							
22b. SIGNATURE <i>Alfred R. Lapan MD</i>	22c. DATE SIGNED <i>Nov 9, 1968</i>	22d. PHYSICIAN'S NAME (Type) <i>Alfred R. Lapan, MD</i>	22e. ADDRESS <i>CLINTON, MD.</i>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE <i>11/13/68</i>	23c. NAME OF CEMETERY OR CREMATORIUM ADDRESS <i>St. Peter's Church Waldorf Charles Md.</i>	23d. LOCATION (City or Town) (County) (State)				
24. FUNERAL DIRECTOR <i>Martell Adams Aquasco, Md.</i>	25a. RECD BY REGISTRAR DATE <i>NOV 15 1968</i>	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>					



MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completed in full, it may be retained by the hospital or attending physician. Then please remove carbon papers pages 1 and 2 from this certificate, page 3 should be detached for use as the burial permit. If any event, within 72 hours after death, should be filed with the State Dept. of Health prior to burial, cremation or removal.

1. DECEASED NAME (Type or print)		First <i>Louis</i>	Middle	Lost <i>Haas</i>	2d. DATE OF DEATH Month <i>November</i>	Year <i>1968</i>	2b. HOUR <i>2:30 PM</i>
3. SEX <b>Male</b>	4. RACE <b>White</b>	5. DATE OF BIRTH <b>Jan. 12, 1905</b>		6. AGE (In years lost birthday) <b>63</b>	7. IF UNDER 1 YEAR MONTHS <b>YRS.</b>	8. IF UNDER 24 HRS. HOURS <b>MIN.</b>	
7a. BIRTHPLACE (State or foreign country) <b>Russia</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH <b>Prince Georges</b>		
10. CITY OR TOWN OF DEATH <b>Cheverly</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Pr. Geo. Gen. Hospital</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>Retail Merchant</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Hardware</b>	
13a. USUAL RESIDENCE (Where deceased lived, if institution admission) STATE <b>Md.</b>		13b. CITY OR TOWN <b>Riverdale</b>		13d. INSIDE CITY LIMITS? <b>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></b>	13e. STREET AND NUMBER <b>5600 54th Avenue</b>		
14. FATHER'S NAME First <b>Joseph</b>		Middle <b>H.</b>	Lost <b>Haas</b>	15. MOTHER'S MAIDEN NAME First <b>Mary</b>		Lost <b>??</b>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <b>No</b>		16b. SOCIAL SECURITY NO. <b>577-48-1549</b>		17. INFORMANT <b>Jean Haas, Same as 13</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>A-V Heart Block (Cardiac Arrest)</b>						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>15 minutes</b>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost <b>44-X</b>		DUE TO, OR AS A CONSEQUENCE OF (b) <b>Hypertensive Cardio-Vascular Disease</b>				<b>Vudeterative</b>	
DUE TO, OR AS A CONSEQUENCE OF (c) <b>Generalized Arterio-Sclerosis</b>						<b>Vudeterative</b>	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 <b>Obstructive Vascular Disease, Carotid Arteries, bilateral (old) 1963</b>						<b>Cerebral Thrombosis</b>	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? <b>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></b>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. MEDICAL CERTIFICATION ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.	City or Town	County	
22a. I certify that (I) (this hospital) attended the deceased from <b>June 27, 1968</b> , to <b>Nov 30 1968</b> , that (I) (we) last saw the deceased alive on <b>Nov 23 1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>George L Ball</i>		22c. DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22d. DATE SIGNED <b>Dec 1, 1968</b>			
22d. PHYSICIAN'S NAME (Type) <b>George L Ball</b>		22e. ADDRESS <b>10620 Georgia Ave Silver Spring Md.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>12-3-1968</b>		23c. NAME OF CEMETERY OR CREMATORIAL <b>Ft. Lincoln Cemetery</b>		23d. LOCATION (City or Town) <b>Colmar Manor</b>	
24. FUNERAL DIRECTOR <b>Golding Funeral Home 4217 9th St. N.W. Washington D.C.</b>		ADDRESS <b>4217 9th St. N.W. Washington D.C.</b>		25a. RECD. BY REGISTRAR DATE <b>DEC 6 1968</b>	25b. REGISTRAR'S SIGNATURE <i>Charles Juge</i>		



Item6 FilmG407 12/5/68 kk MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

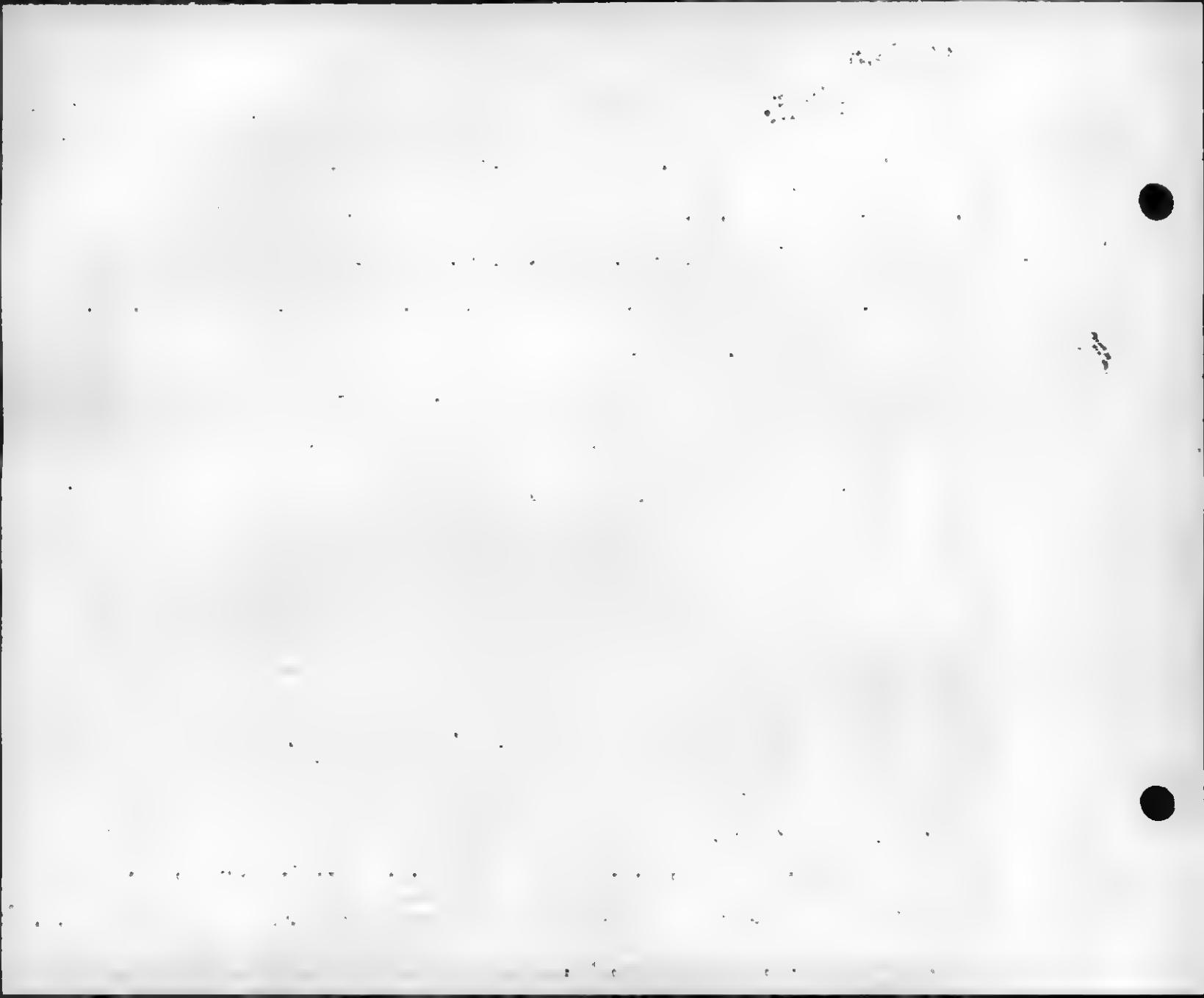
16342

CERTIFICATE OF DEATH

1635

**HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.  
**FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician or attending physician and director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 4 and 5 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 DECEASED NAME (Type or print)	First <b>MARY</b>	Middle <b>ELIZABETH</b>	Last <b>HAIRE</b>	2a DATE OF DEATH Month <b>11</b>	Day <b>22</b>	Year <b>1968</b>	2b HOUR <b>1201 P.M.</b>		
3 SEX <b>FEMALE</b>	4 RACE <b>CAU.</b>	S. DATE OF BIRTH <b>29 JUNE 1891</b>	6 AGE (In years last birthday) <b>78 yrs.</b>	7 IF UNDER 24 HRS. MONTHS <b>0</b>	YEAR <b>0</b>	IF UNDER 24 HRS. MONTHS <b>0</b>	MIN <b>0</b>		
7a BIRTHPLACE (State or foreign country) <b>So. CAROLINA</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH <b>PRINCE GEORGE</b>	Md					
10. CITY OR TOWN OF DEATH <b>CHEVERLY</b>	11 NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) <b>PRINCE GEO. GENERAL HOSP.</b>	12a USUAL OCCUPATION (Kind of work done during most of work life, even if retired) <b>HOUSEWIFE</b>	12b. KIND OF BUSINESS OR INDUSTRY <b>HOME</b>						
13a USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE <b>MD.</b>	13b COUNTY <b>PRINCE GEO.</b>	13d INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	13e. STREET AND NUMBER <b>1961 ADDISON RD. SO.</b>						
14. FATHER'S NAME First <b>Jackson</b>	Middle <b>B.</b>	Last <b>Caston</b>	15. MOTHER'S MAIDEN NAME First <b>Ida</b>	Middle	Last <b>Young</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <b>NO</b>	16b. SOCIAL SECURITY NO (If yes give war or dates of service)	17 INFORMANT <b>James W. Haire - Same as # 13</b>	Address						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <i>acute thoracic &amp; myocard coronary artery</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) <i>Coronary artery sclerosis</i> DUE TO, OR AS A CONSEQUENCE OF (c)				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>3 hrs</b> <b>2 years</b>					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b># 201</b>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21a. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.	City or Town	County	State		
22a. I certify that (I) (this hospital) attended the deceased from <b>11/21/68</b> , 19 <b>to</b> <b>11/21/68</b> , 19, that (I) (we) last saw the deceased alive on <b>11/21/68</b> , 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>L.R. Levitsky, M.D.</i>		DEGREE <b>ATTENDING PHYS</b>	22c. MED. DIRECTOR <input checked="" type="checkbox"/>	STAFF PHYS <input type="checkbox"/>	DATE SIGNED <b>11-23-68</b>				
22d. PHYSICIAN'S NAME (Type) <b>Leon R. Levitsky, M.D.</b>		22e. ADDRESS <b>3408 R.I. Ave., Mt. Rainier, Md.</b>							
23a BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>11-26-68</b>	23c. NAME OF CEMETERY OR CREMATORIUM <b>Bethlehem Baptist Church</b>	23d. LOCATION (City or Town) <b>Lancaster</b>	(County) <b>Lancaster</b>	(State) <b>S.C.</b>				
24. FUNERAL DIRECTOR <b>F. Gasch &amp; Sons, Hyattsville, Md.</b>			25a. REC'D BY REGISTRAR <b>NOV 27 1968</b>	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>					



MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

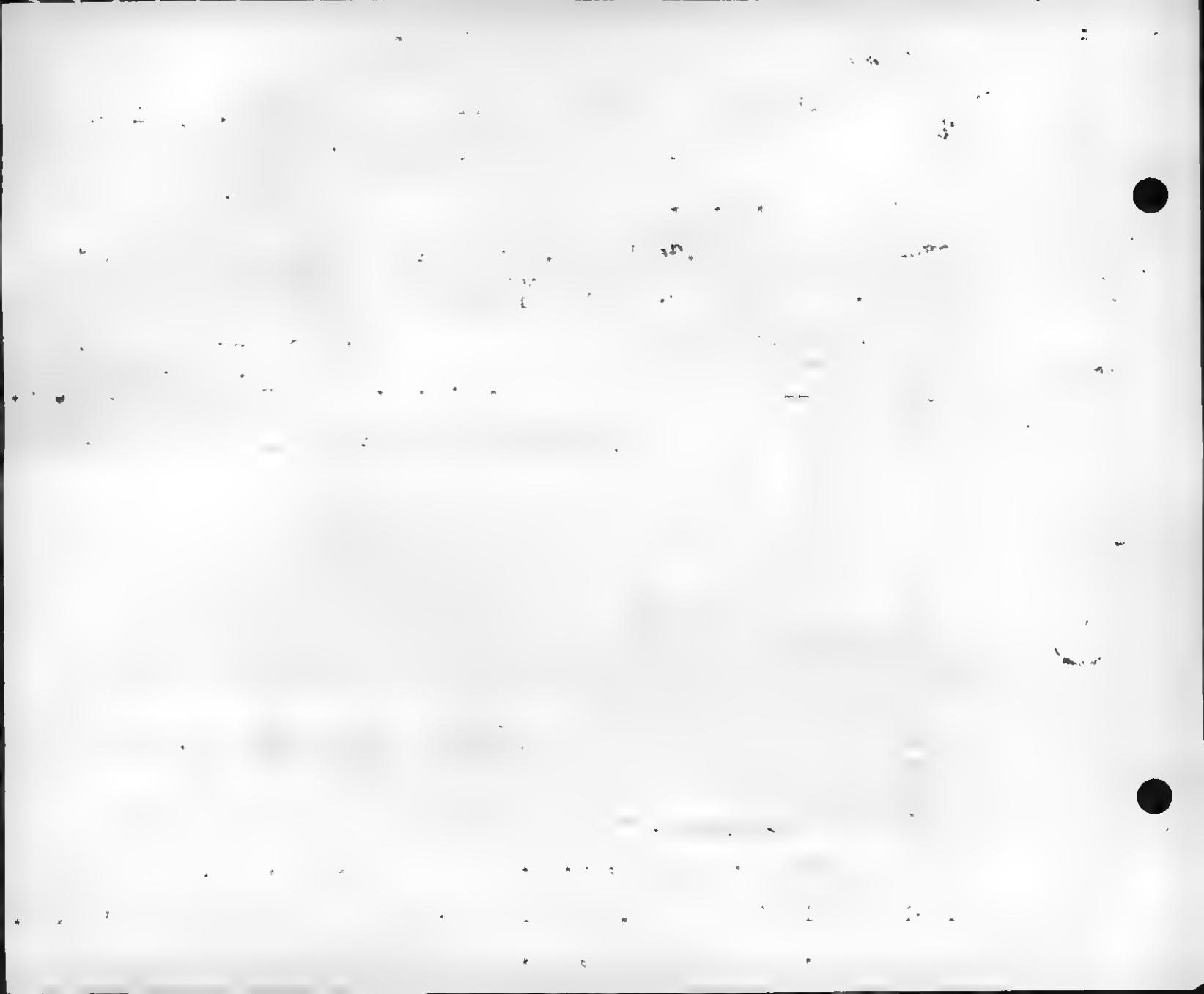
16343

1635

**10 HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.  
 Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove part II and file with the State Dept. of Health prior to burial, cremation or removal, and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print) <b>Alice</b>				First	Middle	Last	2d. DATE OF DEATH Month <b>Nov.</b> Day <b>1,</b> Year <b>1968</b>	2b. HOUR <b>10:50 AM</b>				
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH <b>Feb. 14, 1888</b>		6 AGE (In years last birthday) <b>80</b> YRS.		IF UNDER 1 YEAR MONTHS	IF UNDER 24 HRS. DAYS	2b. HOUR HOURS	2b. HOUR MIN	
7a. BIRTHPLACE (State or foreign country) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Prince Georges</b>						
10 CITY OR TOWN OF DEATH <b>Cheverly</b>			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Pr. Geo's Gen. Hospital</b>			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Housewife</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>			
13a USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE <b>Md.</b>		13b COUNTY <b>Pr. Geo's</b>		13c CITY OR TOWN <b>Upper Marlboro</b>		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER <b>Main Street</b>				
14. FATHER'S NAME First <b>Benjamin</b> Middle <b>Frances</b> Last <b>Harris</b>				15. MOTHER'S MAIDEN NAME First <b>Leonore</b> Middle <b>--</b> Last <b>Rainier</b>								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <b>No</b>		16b. SOCIAL SECURITY NO. <b>_____</b>		17 INFORMANT <b>Mrs. Mary H. Tucker</b> Address <b>Main Street</b> <b>Upper Marlboro, Md.</b>						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>3 weeks</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral Thrombosis</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)												
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. <b>1301st</b>		City or Town <b>Upper Marlboro</b>		County <b>Prince Georges</b>		State <b>Md.</b>		
22a. I certify that (I) (this hospital) attended the deceased from <b>1968</b> , to <b>1968</b> , that (I) (we) last saw the deceased alive on <b>1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE <i>Robert B. Sasscer</i>		DEGREE <b>Robert B. Sasscer, M. D.</b>		ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <b>11/1/68</b>		
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS <b>Upper Marlboro, Maryland 20870</b>										
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>11/4/68</b>		23c. NAME OF CEMETERY OR CREMATORIAL <b>Mt. Carmel Cemetery</b>		23d. LOCATION (City or Town) <b>Upper Marlboro</b>		(County) <b>Prince Georges</b>		(State) <b>Md.</b>		
24. FUNERAL DIRECTOR <b>Ritchie Bros. Upper Marlboro, Md.</b>		ADDRESS				25a. REC'D BY REGISTRAR <b>Charles Judge</b>		25b. REGISTRAR'S SIGNATURE <b>NOV 12 1968</b>				
VR A15 (4) 30M REV 1/68												



## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## CERTIFICATE OF DEATH

16344

16354

**HOSPITAL OR ATTENDING PHYSICIAN:** This law requires that the death certificate be executed within 24 hours after death.  
 Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. If any part of the certificate is to be retained by the funeral director, page 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours of death.

1. DECEASED NAME (Type or print)	First <b>Herbert</b>	Middle <b>C.</b>	Lost	2a. DATE OF DEATH Month <b>Nov</b>	Year <b>15, 1968</b>	2b. HOUR 5:20 A.M.	
3. SEX <b>Male</b>	4 RACE <b>Caucasian</b>	S. DATE OF BIRTH <b>3/23/98</b>	6. AGE (In years lost b'day) <b>70 yrs.</b>	IF UNDER 1 YEAR MONTHS <b>0</b>		IF UNDER 24 HRS. HOURS <b>0</b>	
7a. BIRTHPLACE (State or foreign country) <b>New York</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH <b>Prince George's Md</b>				
10. CITY OR TOWN OF DEATH <b>Cheverly</b>	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Prince Geo. Gen'l Hospital</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>Retired Rail Carrier</b>		12b. KIND OF BUSINESS OR INDSTRY <b>U.S. Government</b>		
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <b>Maryland</b>	13b. COUNTY <b>Prince George's</b>	13c. CITY OR TOWN <b>Bowie</b>	13d. INSIDE CITY LIMIT <b>YES <input type="checkbox"/> NO <input type="checkbox"/></b>	13e. STREET AND NUMBER <b>6610 Alexis Drive</b>			
14. FATHER'S NAME <b>Charles Hann</b>	First	Middle	Last	15. MOTHER'S MAIDEN NAME First <b>Christina Crocoll</b>	Middle	Last	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <b>Yes</b>	16b. SOCIAL SECURITY NO <b>579 46 4385</b>	17. INFORMANT <b>Frieda E Hann</b>	Address <b>Bowie, Md.</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute Pulmonary Edema</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) <i>Cord Lesions metaplastic</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Oscillation of lung</i> .						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>11-10-68</b>	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)						<b>10-20-68</b>	
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? <b>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></b>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (At Home, Farm, Street, Factory, Office Building, etc.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State		
22a. I certify that (I) <input type="checkbox"/> attended the deceased from <b>Sept. 30, 1968</b> to <b>Nov. 15, 1968</b> , that (I) <input type="checkbox"/> last saw the deceased alive on <b>Nov. 15, 1968</b> , and that in (my) <input type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above, (I) <input type="checkbox"/> (did) <input type="checkbox"/> view the body after death.						22c. DATE SIGNED <b>11-15-68</b>	
22b. SIGNATURE <i>George Hageage</i>	DEGREE <b>ATTENDING PHYS</b>	<input checked="" type="checkbox"/> MED DIRECTOR	<input type="checkbox"/> STAFF PHYS				
22d. PHYSICIAN'S NAME (Type) <b>George Hageage, M.D.</b>	22e. ADDRESS <b>3717 38th Ave., Cottage City, Md. 20722</b>						
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>Nov 18, 1968</b>	23c. NAME OF CEMETERY OR CREMATORIUM <b>Cedar Hill Cemetery</b>	23d. LOCATION (City or Town) <b>Suitland</b>	(County) <b>Pro Geo</b>	(State) <b>Md.</b>		
24. FUNERAL DIRECTOR <b>F. Gasch's Sons</b>	ADDRESS <b>Hyattsville, Md.</b>	25a. REC'D BY REGISTRAR DATE <b>NOV 19 1968</b>	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>				



**MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201**

**CERTIFICATE OF DEATH**

**NO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**NO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. **NO** **Hospital**, **Attending Physician**, **Funeral Director**, **State Dept. of Health** or **any other person** should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours of the death.

**M**UNERAL  
**FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH		2b. HOUR				
		Ola	Violet	Harmon	21	15	1968	7 <sup>55</sup>	AM		
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years lost birthday)		IF UNDER 24 HRS			
Female		Caucasian		9-13-1896		72	YRS.	MONTHS	DAYS	HOURS	MIN
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH					
Maryland		U.S.A.				Prince Georges					
10. CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY					
Greenbelt, Md		Greenbelt Convalescent Center		Housewife		Housewife					
13a. USUAL RESIDENCE (Where deceased lived, if institution admission) STATE		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER					
Maryland		Pr. Georges Hyattsville		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		5620 - 31st Ave					
14. FATHER'S NAME		First	Middle	Last	15. MOTHER'S MAIDEN NAME		First	Middle	Last		
		Luther		Watson			Mary		Ball		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown?		16b. SOCIAL SECURITY NO.		17. INFORMANT		Address					
(If yes give war or dates of service)		577-30-8375		Nursing Home Records Greenbelt Md							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)		Malignant Carcinoma						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
1558 Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause last.		DUE TO, OR AS A CONSEQUENCE OF (b) Cervix of Colon						several months 4+ year			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, notify med cal examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No.		City or Town		County		State
22a. I certify that (I) (this hospital) attended the deceased from 1963, to 1968, that (I) (we) last saw the deceased alive on 11-14 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>Donald C. Edgren</i>		DEGREE		ATTENDING PHYS.		<input checked="" type="checkbox"/> MED. DIRECTOR	<input type="checkbox"/> STAFF PHYS.	22c. DATE SIGNED			
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS		Hyattsville, Md.							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE Nov 19, 1968		23c. NAME OF CEMETERY OR CREMATORIUM Cedar Hill Cemetery		23d. LOCATION (City or Town) Suitland Pro Geo		(County) Md.		(State)	
24. FUNERAL DIRECTOR F. Gasch's Sons		ADDRESS Hyattsville, Md.		25a. REC'D BY REGISTRAR DATE NOV 19 1968		25b. REGISTRAR'S SIGNATURE Ministry Judge					



MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16346-1

CERTIFICATE OF DEATH

**HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be signed by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in, it may be retained by the hospital or attending physician. Then please remove carbon paper, pages 1 and 2, from the back of this certificate. If you do not have a burial permit, then please attach a burial permit. Then please sign and date the back of this certificate. This certificate, page 3, should be detached for use as the burial permit. It should be filed with the State Dept. of Health prior to a burial, cremation, or removal, and in any event, within 72 hours after death.

1 DECEASED NAME (Type or print)		First <b>Sherman</b>	Middle <b>E.</b>	Last <b>Harper</b>	2a DATE OF DEATH Month <b>Nov.</b> Day <b>21,</b> Year <b>1968</b>	2b HOUR <b>1:45 PM</b>	
3. SEX <b>Male</b>		4. RACE <b>Caucasian</b>		S. DATE OF BIRTH <b>Jan. 26, 1910</b>	6. AGE (in years less birthday) <b>58</b> YRS	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS HOURS MIN
7a BIRTHPLACE (State or foreign country) <b>W Va</b>		7b. CIT ZEN OF WHAT COUNTRY? <b>USA</b>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> W DIVORCED <input checked="" type="checkbox"/> P. DIVORCED <input type="checkbox"/>	9 COUNTY OF DEATH <b>Prince George's</b>		
10 CITY OR TOWN OF DEATH <b>Cheverly</b>		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Prince Geo. Gen'l Hospital</b>		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>Breaklayer</b>		12b KIND OF BUSINESS OR INDUSTRY <b>Construction</b>	
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <b>Maryland</b>		13c CITY OR TOWN <b>Anne Arundel</b>		13d INSIDE CITY LIMIT YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e STREET AND NUMBER <b>Annapolis Junction</b>		
14 FATHER'S NAME First <b>unknown</b>		15. MOTHER'S MAIDEN NAME First <b>unknown</b>					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <b>yes</b>		16b. SOCIAL SECURITY NO		17 INFORMANT <b>Christine Kelly</b>		Address <b>546 Embassy Lane, Beltsville, Md.</b>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Cardiac and Respiratory Arrest</b>						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
4109 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause Last		DUE TO, OR AS A CONSEQUENCE OF (b) <b>Acute Anteroseptal Myocardial Infarction</b>					
		DUE TO, OR AS A CONSEQUENCE OF (c) <b>Arteriosclerotic heart disease.</b>					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY?	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	Yes		
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, not by medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.	City or Town	County	State
22a. I certify that <b>(s)</b> (this hospital) attended the deceased from <b>Nov. 14, 1968</b> , to <b>Nov. 21, 1968</b> , that <b>(s)</b> (we) last saw the deceased alive on <b>Nov. 21, 1968</b> , and that in <b>(s)</b> (our) opinion death occurred on the date and hour and from the causes stated above <b>(s)</b> (we) (did) <b>(did not)</b> view the body after death.							
22b SIGNATURE <b>Luis Bentolila</b>		DEGREE ATTENDING PHYS	<input type="checkbox"/> MED DIRECTOR	<input type="checkbox"/> STAFF PHYS	22c. DATE SIGNED <b>Nov. 21, 1968</b>		
22d. PHYSICIAN'S NAME (Type) <b>Luis Bentolila, M. D.</b>		22e. ADDRESS <b>Prince Geo. Gen'l Hospital, Cheverly, Md.</b>					
23a BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b DATE <b>11-25-68</b>		23c NAME OF CEMETERY OR CREMATORIAL <b>Balt Natl</b>		23d LOCATION (City or Town) (County) (State) <b>Baltimore Md.</b>	
24. FUNERAL DIRECTOR <b>Bonadore J.H. funeral mch</b>		ADDRESS		25a. REC'D BY REGISTRAR <b>NOV 29 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
CERTIFICATE OF DEATH

16347

16361

**10 HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.  
**Page 4** may be retained by the hospital or attending physician.  
**10 FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 DECEASED NAME (Type or print)		First <b>Baby Boy</b>	Middle	Last <b>Harrellson</b>	2a. DATE OF DEATH Month <b>Nov.</b> 17 Day <b>68</b> Year	2b. HOUR <b>6:30AM</b>	
3 SEX <b>Male</b>	4. RACE <b>Cauc.</b>	5. DATE OF BIRTH <b>11-17-68</b>			6. AGE (in years lost birthday) <b>YRS</b>	IF UNDER 1 YEAR <b>MONTHS</b> - IF UNDER 24 HRS. <b>HOURS</b> <b>50</b> <b>MIN</b>	
7a BIRTHPLACE (State or foreign country) <b>Maryland</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Prince Georges</b> Md.			
10 CITY OR TOWN OF DEATH <b>Cheverly</b>	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Prince Georges Gen. Hosp.</b>		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b KIND OF BUSINESS OR INDUSTRY		
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <b>Md.</b>	13b. COUNTY <b>Prince Georges</b>	13c CITY OR TOWN <b>Landover</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER <b>1950 Brightseat Road</b>		
14. FATHER'S NAME First <b>Jack Parker Harrellson</b>	Middle	Last	15. MOTHER'S MAIDEN NAME First <b>Nance Fisher</b>	Middle Last			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown)	16b SOCIAL SECURITY NO. (If yes give war or dates of service)	17 INFORMANT			Address		
<b>18 CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Fever, Influenza</i>						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DUE TO, OR AS A CONSEQUENCE OF (b) <i>Probable - a telec Tax</i>							
DUE TO, OR AS A CONSEQUENCE OF (c)							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY OFFICE BUILDING, ETC)	21f LOCATION Street or R.F.D. No.	City or Town	County	State	
22a. I certify that <input type="checkbox"/> (this hospital) attended the deceased from <b>Nov. 17, 1968</b> , to <b>Nov. 17, 1968</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>Nov. 17, 1968</b> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) did <input type="checkbox"/> view the body after death.							
22b. SIGNATURE <i>Bernardo Alvarado</i>		DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input checked="" type="checkbox"/>	22c. DATE SIGNED <b>Nov. 22, 1968</b>		
22d. PHYSICIAN'S NAME (Type)		22e ADDRESS <b>Prince Geo. Gen'l Hospital, Cheverly, Md.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <b>11/30/68</b>	23c. NAME OF CEMETERY OR CREMATORIY <b>Prince George's General Hospital</b>		23d. LOCATION (City or Town) (County) (State) <b>Cheverly, Maryland</b>		
24. FUNERAL DIRECTOR <i>William A. Parker</i>		ADDRESS <b>William A. Parker, Assoc. Administrator</b>	25a. REC'D. BY REGISTRAR <b>DEC 3 1968</b>		25b. REGISTRAR'S SIGNATURE <i>Charles George</i>		

7022

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

16343

16343

**10 HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

**10 FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician or attending physician, page 4 may be reigned by the hospital or attending physician. Then please, remove carbon papers. Pages 3 should be detached for use as the burial permit. Then please, remove carbon papers. Pages 3 should be filed with the State Dept. of Health prior to burial, motion, or removal, and any event, within 72 hours after death.

1 DECEASED NAME (Type or print)		First <b>Joseph</b>	Middle <b>V.</b>	Lost <b>Harris</b>	2a DATE OF DEATH Month Day Year <b>July 14, 1968</b>	2b. HOUR <b>1:35 P.M.</b>		
3 SEX <b>Male</b>		4. RACE <b>Negro</b>		5. DATE OF BIRTH <b>7/14/1902</b>		6. AGE (In years, months & days) <b>66</b>	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.
7a BIRTHPLACE (State or foreign country) <b>Indiana</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8 MARRIED <input checked="" type="checkbox"/> EVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH <b>Prince Georges</b>		
10 CITY OR TOWN OF DEATH <b>Glenn Dale</b>		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Glenn Dale Hospital</b>		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Mover</b>		12b KIND OF BUSINESS OR INDUSTRY <b>Md.</b>		
13a USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE <b>Wash., D.C.</b>		13b COUNTY		13c CITY OR TOWN <b>Wash., D.C.</b>		13d INSIDE CITY LIMITS? <b>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></b>	13e STREET AND NUMBER <b>5000 C St., S. E.</b>	
14. FATHER'S NAME First <b>Joseph</b>		Middle <b>--</b>	Lost <b>Harris</b>	15. MOTHER'S MAIDEN NAME First <b>Mattie</b>		Middle <b>--</b>	Lost <b>Clayton</b>	
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <b>No</b>		16b. SOCIAL SECURITY NO <b>unknown</b>		17. INFORMANT <b>D. C. General Hospital &amp; previous Glenn/</b>		Address <b>Dale Hosp. records</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Pulmonary tuberculosis</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>3yr., 1mo.</b>								
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c)								
DUE TO, OR AS A CONSEQUENCE OF (b)								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>Bronchopleural fistula, left.</b>								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? <b>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></b>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY OFFICE BUILDING ETC.)		21f LOCATION Street or R.F.D. No	City or Town	County	State	
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>11/24/68</b> , to <b>11/27/68</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>11/27/68</b> , and that <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above <input checked="" type="checkbox"/> (we) (did) <input checked="" type="checkbox"/> view the body after death.								
22b. SIGNATURE <i>Moe Weiss</i>		DEGREE ATTENDING PHYS	<input type="checkbox"/>	MED. DIRECTOR	<input checked="" type="checkbox"/>	STAFF PHYS	<input type="checkbox"/>	22c. DATE SIGNED <b>11/27/68</b>
22d PHYSICIAN'S NAME (Type) <b>Moe Weiss, M. D.</b>		22e ADDRESS <b>Glenn Dale Hospital Glenn Dale, Maryland</b>						
23a BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b DATE <b>12-3-68</b>	23c NAME OF CEMETERY OR CREMATORIAL <b>HARMONY cem</b>			23d LOCATION (City or Town) (County) (State) <b>LANDOVER, Md</b>		
24 FUNERAL DIRECTOR <i>Frazier F. H. Golphas, B. Farrell - 357 R.I. Ave.</i>		ADDRESS		25a REC'D BY REGISTRAR DATE <b>DEC 5 1968</b>		25b. REGISTRAR'S SIGNATURE <i>Charles George</i>		



MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
CERTIFICATE OF DEATH

16349

1633

**HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 4 hours after death.  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

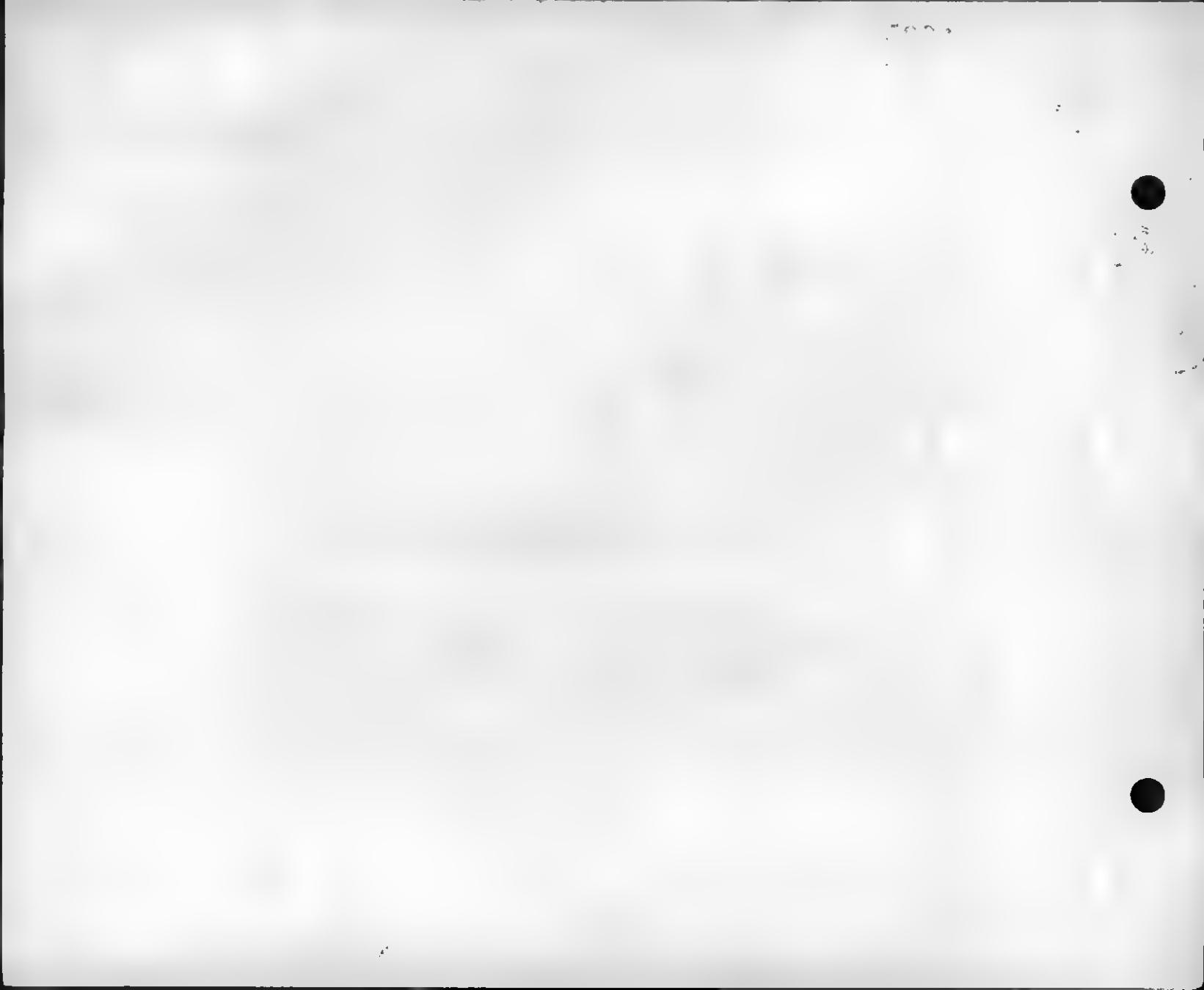
1. DECEASED NAME (Type or print) <b>James W. Harrison Jr.</b>				2. DATE OF DEATH Month <b>Nov</b>	2b. HOUR 2b. HOUR <b>3:00 P.M.</b>
3. SEX <b>male</b>	4 RACE <b>white</b>	5. DATE OF BIRTH <b>May 31, 1910 -</b>	6. AGE (in years last birthday) <b>58</b>	7. IF UNDER 1 YEAR MONTHS <b>YRS.</b>	8. IF UNDER 24 HRS. DAYS HOURS MIN.
7a. BIRTHPLACE (State or Foreign country) <b>Indiana</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH <b>Pro Geo</b>	
10. CITY OR TOWN OF DEATH <b>Bladensburg,</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>4235 58th ave</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>Salesman</b>	
13a. USUAL RESIDENCE (Where deceased lived, if institution admission) STATE <b>Md</b>		13b. COUNTY <b>Pro Geo</b>	13c. CITY OR TOWN <b>Bladensburg</b>	13d. INSIDE CITY LIMITS? <b>YES</b>	13e. STREET AND NUMBER <b>4235 58th ave.</b>
14. FATHER'S NAME <b>James W. Harrison</b>		15. MOTHER'S MAIDEN NAME <b>Bertha M. Buckland</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <b>Yes</b>	16b. SOCIAL SECURITY NO. <b>WW 11 579 01 4629</b>	17. INFORMANT <b>Elen E Harrison</b>	Address <b>Bladensburg, Md.</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Respiratory Paralysis</b> , DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) <b>Arteriosclerosis at Sclerosis about 7 yrs</b> , DUE TO, OR AS A CONSEQUENCE OF (c)					
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>7 days</b>					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? <b>YES</b> <input type="checkbox"/> <b>NO</b> <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) <b>At home, Farm, Street, Factory, Office Building, etc.</b>		
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. City or Town County State		
22a. I certify that (I) (this hospital) attended the deceased from <b>sent</b> , 1967, to <b>Nov 8, 1968</b> , that (I) (we) last saw the deceased alive on <b>Nov 3, 1968</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death					
22b. SIGNATURE <b>Elen E. Weintraub MD</b>		ATTENDING PHYS <b>REGRET</b>		MED DIRECTOR <input type="checkbox"/>	STAFF PHYS <input type="checkbox"/>
22d. PHYSICIAN'S NAME (Type) <b>Wm C Weintraub</b>		22e. ADDRESS <b>Greenbelt, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>Nov. 6, 1968</b>	23c. NAME OF CEMETERY OR CREMATORIUM <b>Washington National</b>	23d. LOCATION (City or Town) <b>Suitland</b>	(County) <b>Pro Geo</b>
24. FUNERAL DIRECTOR <b>F. Gasch's Sons</b>		ADDRESS <b>Hyattsville, Md.</b>		25a. REC'D BY REGISTRAR <b>NOV 8 1968</b>	25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>



**10 HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.  
 Page 4 may be retained by the hospital or attending physician.

**10 FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH												1636..	
1. DECEASED NAME (Type or print)			First	Middle	Last	2. DATE OF DEATH			2b HOUR				
Edward M. Hines					Hines	Month	Day	Year	11	21	68		
3. SEX			4. RACE	5. DATE OF BIRTH			6. AGE (In years last birthday)			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN			
Male			White	2-4-91			77 YRS						
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH				
Wash. DC			U.S.A.						Prince George Md.				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital (give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY				
Clinton			Pinewview Garden			Sheet metal work							
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET AND NUMBER				
Md.			Pr. George Silverhill			YES <input checked="" type="checkbox"/>			2543 Iverson St.				
14. FATHER'S NAME			First	Middle	Last	15. MOTHER'S MAIDEN NAME			First	Middle	Last		
Edward Michael Hines						Emma Martha Adams							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO (If yes give war or dates of service)			17. INFORMANT			Address				
No			578-07-268-A			Mes. Ruth Webster							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac arrest / Colic - DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last													
(b) - - - - - & m - - - - - DUE TO, OR AS A CONSEQUENCE OF (c) 15-612 Hypoxia -													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
						YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)									
21d. INJURY OCCURRED Wh. in <input type="checkbox"/> Not wh. e <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No		City or Town		County		State			
22a. I certify that (I) (this hospital) attended the deceased from <u>11-20</u> , 19 <u>68</u> , to <u>11-21</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>11-20</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE			22c. DEGREE			ATTENDING PHYS			MED DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS <input type="checkbox"/>			22d. DATE SIGNED	
Edward M. Hines			Physician			MED DIRECTOR <input checked="" type="checkbox"/>			STAFF PHYS <input type="checkbox"/>			11-21-1968	
22d. PHYSICIAN'S NAME (Type)			22e. ADDRESS										
Alfred R. Appling			Clinton, MD										
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS			23d. LOCATION (City or Town) (County) (State)			Burial, Cremation, Removal			
Burial		11/23/1968		Fair Lincoln			Clinton, MD						
24. FUNERAL DIRECTOR		ADDRESS			25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE						
Mallory		131-11th St. SE					NOV 25 1968		Charles Judge				
VR A15 30M REV													



MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1636.

16351

**10 HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.  
**10 FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation or removal, and in any event, within 72 hours after death.

1 DECEASED NAME (Type or print)		First <b>Mattie</b>	Middle <b>L.</b>	Last <b>Hofmann</b>	2d DATE OF DEATH Month <b>Nov.</b> Day <b>13, 1968</b> Year	2b HOUR <b>A 12:10 M</b>	
3. SEX <b>Female</b>		4. RACE <b>White</b>		S. DATE OF BIRTH <b>25 July 1896</b>	6 AGE (In years last birthday) <b>72</b> YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF OVER 24 HRS HOURS MIN
7a. BIRTHPLACE (State or foreign country) <b>North Carolina</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH <b>Prince George's</b>		
10 CITY OR TOWN OF DEATH <b>Cheverly</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince Geo. Gen'l Hospital</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Housewife</b>	12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <b>Maryland</b>		13c. CITY OR TOWN <b>Prince George's Seat Pleasant</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER <b>6900 George Palmer Highway</b>		
14. FATHER'S NAME First - - - - - Middle <b>Croam</b>		15. MOTHER'S MAIDEN NAME First Middle Last unknown					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <b>No</b>		16b. SOCIAL SECURITY NO (If yes give war or dates of service)		17. INFORMANT Address <b>William Hofmann 6900 Geo. Palmer Hwy.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Acute Congestive Heart Failure. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		DUE TO, OR AS A CONSEQUENCE OF (b) Bilateral pulmonary edema and congestion, severe.					
		DUE TO, OR AS A CONSEQUENCE OF (c) Arteriosclerotic coronary artery disease, severe.					
		PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>Diabetes Mellitus (clinical)</b>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>Yes</b>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No.	City or Town	County	State
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>Nov. 12, 1968</b> , to <b>Nov. 13, 1968</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>Nov. 13, 1968</b> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) did <input checked="" type="checkbox"/> (not) view the body after death.							
22b. SIGNATURE <i>Fidel J. Quintana</i>		DEGREE ATTENDING PHYS	<input type="checkbox"/> MED DIRECTOR	<input type="checkbox"/> STAFF PHYS.	22c. DATE SIGNED <b>Nov. 13, 1968</b>		
22d. PHYSICIAN'S NAME (Type) <b>FIDEL J. QUINTANA</b>		22e. ADDRESS <b>Prince Geo. Gen'l Hospital, Cheverly, Md.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>11-16-68</b>	23c. NAME OF CEMETERY OR CREMATORIAL <b>Washington National Cem.</b>		23d. LOCATION (City or Town) <b>Silver Spring</b>	(County) <b>Md.</b>	(State)
24. FUNERAL DIRECTOR Wilhelm Funeral Home		ADDRESS <b>4308 Suitland Rd. S. L.</b>	25a. NOV. 13, 1968 BY REGISTRAR		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		
			DATE				



**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201**  
**CERTIFICATE OF DEATH**

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the offending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers 1 and 2 shown and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.



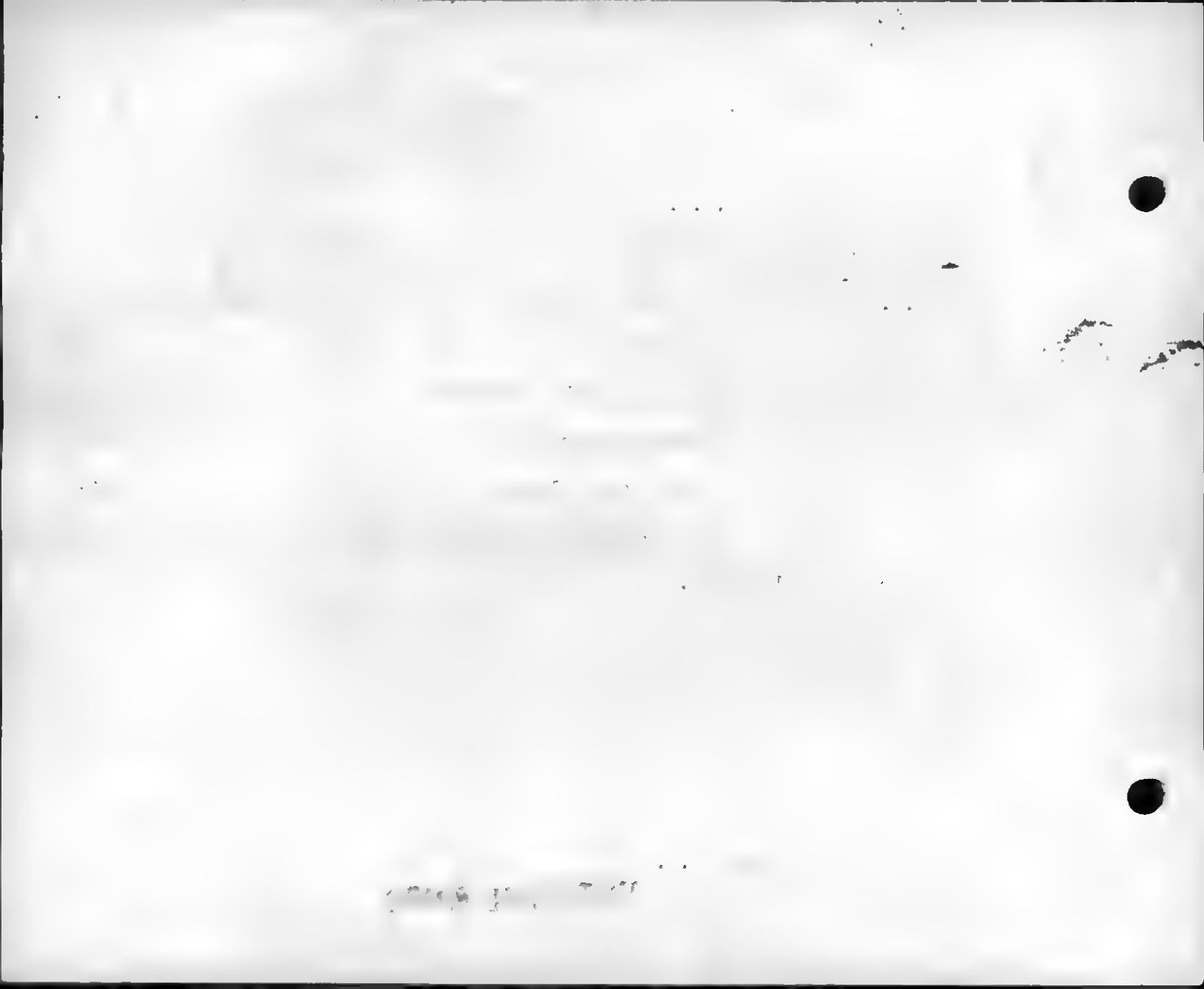
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

**CERTIFICATE OF DEATH**

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1		16353	16367									
1		1 DECEASED NAME (Type or print)			First <b>Charles S.</b>	Middle	Last <b>Huggins</b>	2a DATE OF DEATH Month <b>November</b>	2b HOUR Day <b>14, 1968 A.M.</b>			
2		3. SEX		4 RACE <b>Male White</b>		5. DATE OF BIRTH <b>12/27/1906</b>		6. AGE (in years lost birthday) <b>61 YRS.</b>	IF UNDER 1 YEAR MONTHS <b>0</b>	IF UNDER 24 HRS. HOURS <b>0</b>	IF UNDER 24 HRS. MIN. <b>0</b>	
3		7a BIRTHPLACE (State or foreign country) <b>North Carolina</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>Sep.</b> <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Prince Georges</b>				
4		10 CITY OR TOWN OF DEATH <b>Glenn Dale</b>		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Glenn Dale Hospital</b>		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>Painter</b>		12b KIND OF BUSINESS OR INDUSTRY <b>--</b>				
5		13a USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) STATE <b>D.C.</b>		13b COUNTY <b>Washington</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET AND NUMBER <b>No fixed address</b>				
6		14. FATHER'S NAME First <b>Grant</b>		Middle <b>Huggins</b>	Last	15. MOTHER'S MAIDEN NAME First <b>Nora</b>		Middle	Last <b>Hester</b>			
7		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <b>Yes</b>		16b. SOCIAL SECURITY NO (If yes give year or dates of service) <b>579-03-2392</b>		17. INFORMANT <b>Decedent</b>		Address				
8		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchopneumonia</b>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b>		
9		44dx DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause <b>Acute cor pulmonale</b>								5 days		
10		DUE TO, OR AS A CONSEQUENCE OF <b>Pulmonary emphysema and fibrosis</b>								years		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)												
<b>Fracture of left hip.</b>												
MEDICAL CERTIFICATION 2		19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
							YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No		City or Town		County		State		
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>7/20/68</b> , to <b>11/14/68</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>11/14/68</b> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) did <input checked="" type="checkbox"/> view the body after death.												
22b. SIGNATURE <i>Moe Weiss</i>		DEGREE PHYS	ATTENDING PHYS	<input type="checkbox"/>	MED DIRECTOR	<input checked="" type="checkbox"/>	STAFF PHYS	<input type="checkbox"/>	22c. DATE SIGNED <b>11/14/1968</b>			
22d. PHYSICIAN'S NAME (Type) <b>Moe Weiss, M.D.</b>		22e. ADDRESS <b>Glenn Dale Hospital Glenn Dale, Maryland</b>										
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		23b. DATE <b>11/20/68</b>	23c. NAME OF ENTITLED FOR CREMATION <b>ANATOMICAL BOARD</b>			23d. LOCATION (City or Town) <b>Washington</b>		(County) <b>District of Columbia</b> (State)				
24. FUNERAL DIRECTOR <b>Carl F. Aufrecht</b>		ADDRESS			25a. REC'D BY REGISTRAR DATE <b>NOV 23 1968</b>		25b. REGISTRAR'S SIGNATURE <b>J. J. G.</b>					



'FOR STATE  
HEALTH DEPT.

This certificate should be executed within 24 hours after death if any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 1a. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office, with form DMS, Page 5 may be retained for your files.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

16354 16354

1 DECEASED NAME (Type or Print)		First	M date	Lost	20. DATE KNOWN <input type="checkbox"/> Month Day Year OF ESTI- DEATH MATED <input checked="" type="checkbox"/> 11-14-68 19 8:15pm	2b HOJR
3 SEX	4. RACE	S. DATE OF BIRTH	6 AGE (in years last birthday)	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	2c. DATE PRONONCED DEAD Month Day Year	2d HOUR
Male	White	8-22-1899	69 YRS		11 14 68 19 8:18pm	Md.
7a BIRTHPLACE (State or foreign country) New Jersey		7b CITIZEN OF WHAT COUNTRY? U S A		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Prince George's	
10. CITY OR TOWN OF DEATH Cheverly		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Prince George Hospital			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if part time) Retired	
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE Maryland		13c. CITY OR TOWN County Prince George's Brentwood		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 4403 38th. Street	
14. FATHER'S NAME Unknown		Middle	Lost	15. MOTHER'S MAIDEN NAME Unknown	Middle	Lost
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16b. SOCIAL SECURITY NO (If yes give war or dates of service) 265 05 1042		17. INFORMANT Willard Jackson	ADDRESS Riverdale, Md.	
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH minutes						
18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Heart failure DUE TO, OR AS A CONSEQUENCE OF Arteriosclerotic heart disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF (c)						
unknown						
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 4200						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b.)		
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No	City or Town	County State
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>						
ACTUAL SIGNATURE <i>John Kehoe</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D.			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	22b. DATE SIGNED 11-15-68
EXAMINER'S NAME (Type) John Kehoe MD Riverdale, Md.						
23a. BURIAL, CREMATION REMOVAL (Specify) Burial		23b. DATE Nov 18, 1968	23c. NAME OF CEMETERY OR CREMATORIAL Ft Lincoln Cemetery		23d. LOCATION (City or Town) Colmar Manor Pro Geo	(County) Md.
24. FUNERAL DIRECTOR F. Gasch's Sons		ADDRESS Hyattsville, Md.		25a. REC'D BY REGISTRAR DATE NOV 18 1968	25b. REGISTRAR'S SIGNATURE <i>Charles Juge</i>	

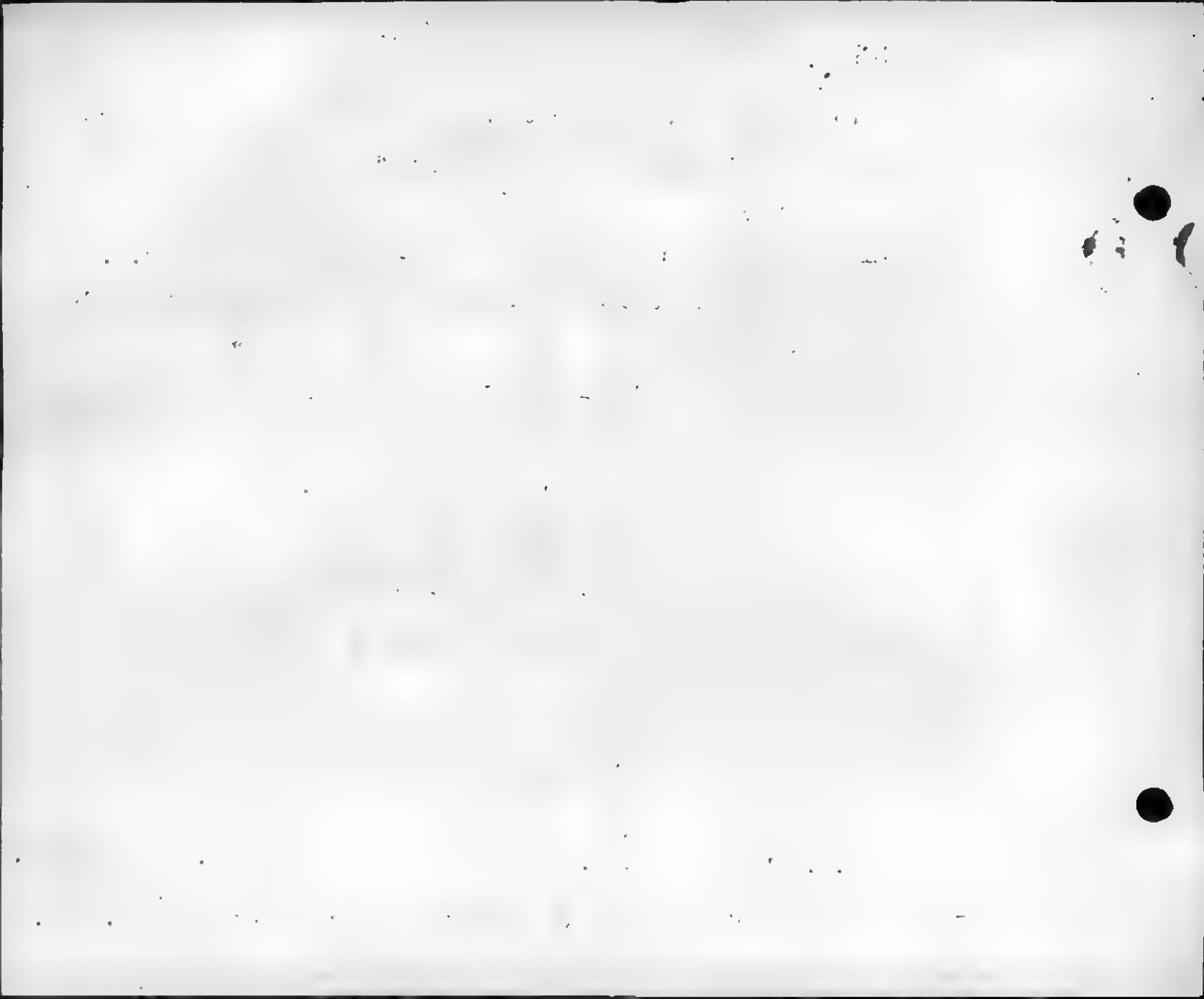


MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

**To HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.  
**To FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print)				First	Middle	Last	2d. DATE OF DEATH Month Day Year	2b. HOUR	
Albert J. Jacobson							11 28 68	M	
3. SEX	4. RACE	5. DATE OF BIRTH			6. AGE (in years last birthday)	F. UNDER 1 YEAR MONTHS DAYS	I. F. UNDER 24 HRS HOURS MIN		
Male	white	8/16/35			63 yrs.				
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		9. COUNTY OF DEATH			
Sweden		USA		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		Prince George's Md.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY		
Riverdale		Belair Memorial			Painter		D.C. Transit		
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE		13c. CITY OR TOWN		13d. RESIDE CITY, MD, TSP	13e. STREET AND NUMBER				
Maryland		Prince Georges Mt. Rainier		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	3307 Chauncey Place				
14. FATHER'S NAME		First	Middle	Last	15. MOTHER'S MAIDEN NAME				
Jacob Jacobson					Maria Nielson				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO		17. INFORMANT		Address			
Yes, no, or unknown		573-10-8163		Hospital Records					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>5 min</u>									
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) <u>Arteriosclerotic heart disease</u>									
DUE TO, OR AS A CONSEQUENCE OF (c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>Gangrene foot c amputation of leg</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
11-24-68		abov			YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town	County	State	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>R.F. Wilkinson</u>		DEGREE	ATTENDING PHYS.	<input type="checkbox"/>	MED. DIRECTOR	<input type="checkbox"/>	STAFF PHYS	<input type="checkbox"/>	22c. DATE SIGNED
22d. PHYSICIAN'S NAME (Type)		R.F. Wilkinson, M. D.			22e. ADDRESS 4400 Queensbury Rd. Riverdale, Md.				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL		23d. LOCATION (City or Town) (County) (State)			
Burial		12/2/68		Cedar Hill Cemetery		Prince Georges Co. Md.			
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
The S.H. Hines Co.		2901 14th St. N.W. Washington, D.C.		DEC 2 1968		Charles Judge			



## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## CERTIFICATE OF DEATH

1000

16356

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the attending physician, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Please send page 3 to the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print)	First Mary	Middle E.	Last Jeffries	2a DATE OF DEATH Nov. 24, Day 1968 Year	2b HOUR 1:15 PM		
3 SEX Female	4 RACE Caucasian	5 DATE OF BIRTH Feb. 13, 1891		6 AGE (In years last birthday) 77 yrs	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN		
7a. BIRTHPLACE (State or foreign country) WASHINGTON, D.C.	7b. CITIZEN OF WHAT COUNTRY? U.S.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Prince George's Md				
10 CITY OR TOWN OF DEATH Cheverly	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Prince Geo. Gen'l Hospital		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Housewife		12b KIND OF BUSINESS OR INDSTRY		
13a US.A. RESIDENCE (Where deceased lived, if institution before admission) STATE Maryland	13b. COUNTY Prince George's	13c CITY OR TOWN Hyattsville	13d INSIDE CITY LIMITS YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e STREET AND NUMBER 5706 Ager Rd.			
14. FATHER'S NAME Unknown	First Unknown	Middle HURLEY	Last Unknown	MOTHER'S MAIDEN NAME Unknown			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, No, or Unknown No	16b. SOCIAL SECURITY NO. 213561473	17. INFORMANT CHARLES D. JEFFRIES, 4013 WARNER AV HYATTSVILLE, MARYLAND ADDRESS					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <i>Cardiac arrest</i> 4101 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <i>or myocardial infarction</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Alimentary tract disease</i> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE, BUILDING ETC)	21f. LOCATION Street or RFD No	City or Town	County	State	
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from Nov. 24, 1968, to Nov. 24, 1968, that (I) <input checked="" type="checkbox"/> last saw the deceased alive on Nov. 24, 1968, and that <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) <input checked="" type="checkbox"/> view the body after death.							
22b. SIGNATURE <i>Fidel J. Quintana</i>		DEGREE ATTENDING PHYS	<input checked="" type="checkbox"/> MED DIRECTOR	<input type="checkbox"/> STAFF PHYS.	22c. DATE SIGNED 11-25-68		
22d. PHYSICIAN'S NAME (Type) FIDEL J. QUINTANA		22e. ADDRESS 8715 1st Ave, S. S., MD					
23a. BURIAL, CREMATION ON, REMOVAL (Specify) BURIAL	23b. DATE 11-27-1968	23c. NAME OF CEMETERY OR CREMATORIUM FORT LINCOLN CEM	23d. LOCATION (City or Town) COLMAR MANOR MARYLAND (County) (State)				
24. FUNERAL DIRECTOR W. W. Chambers		ADDRESS RIVERDALE MD 20234 PRICE \$100	25a. RECD BY REGULAR MAIL NOV 29 1968 RECD BY AIR MAIL DATE NOV 29 1968 Judge				



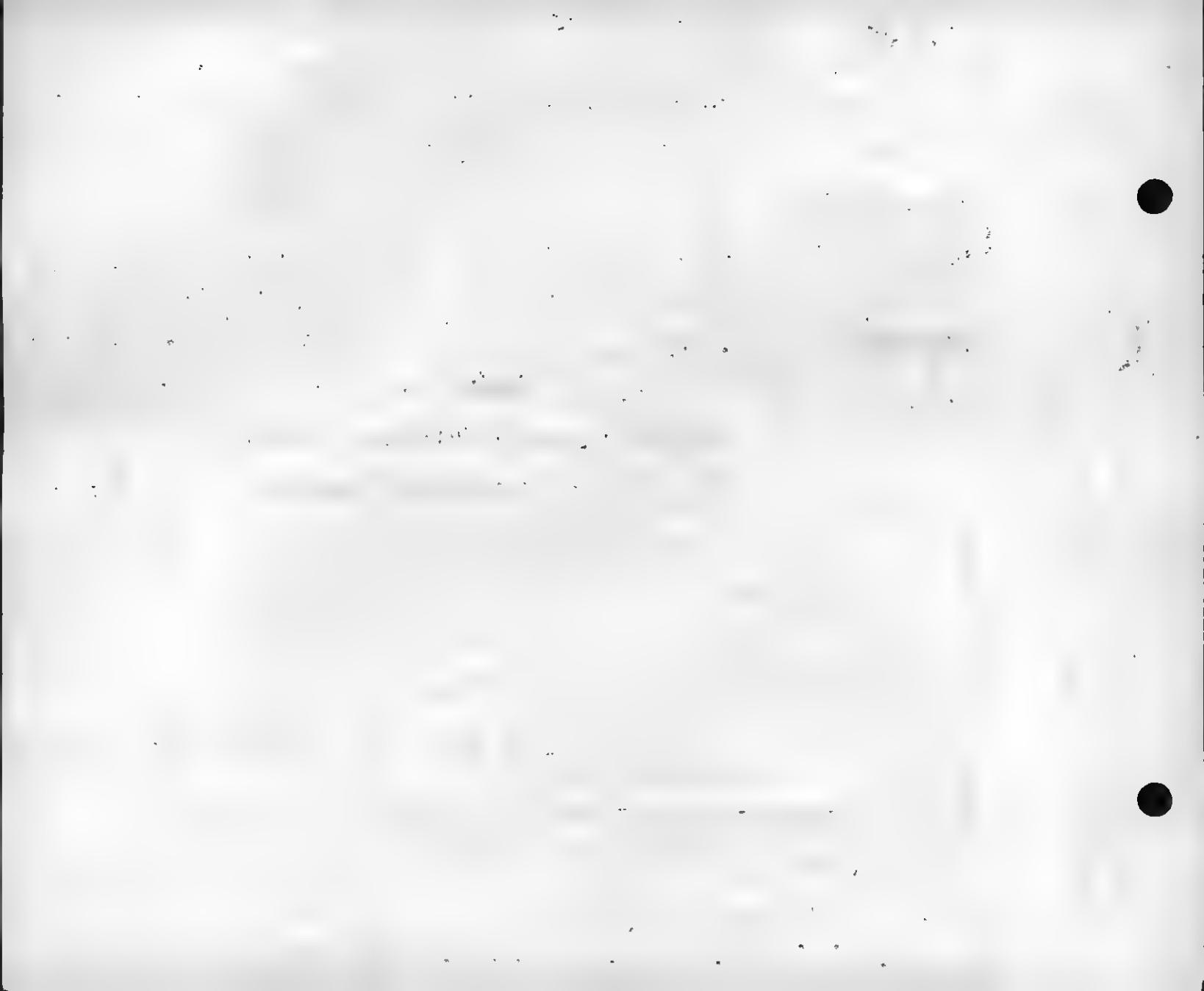
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

**Page 4 may be retained by the hospital or attending physician.**  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 4 may be retained by the funeral director, page 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours of death.

1 DECEASED NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH Month Day Year	2b. HOUR 10 P.M.
Curtis Chester JOHNSON					11 29 68	
3. SEX	4. RACE	S. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN	
Male	white	JAN 4, 1886	82 yrs.			
7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	9. COUNTY OF DEATH			
Minnesota USA	U.S.A.		Prince Georges			
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY			
Lanham	6911 Nashville Rd	Premier	Fire Dept			
13a. USUAL RESIDENCE (Where deceased lived if institution: Residence before admission) STATE	13b. COUNTY	13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	13e. STREET AND NUMBER			
MD	Prince George	Lanham	6911 Nashville Rd			
14. FATHER'S NAME	First	Middle	Last	15. MOTHER'S MAIDEN NAME	First	Middle
John	Jesse	Johnson	Julia	Amanda	Stein Wolf	Last
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown	16b. SOCIAL SECURITY NO.	17. INFORMANT	Address			
No	514-46-3110	Sadie Johnson (wife)	6911 Nashville Rd			
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute renal failure and uremia</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Prostatic carcinoma, invasive</u> DUE TO, OR AS A CONSEQUENCE OF (c)						
19. PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (o)						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No	City or Town	County	State
22a. I certify that (I) (this hospital) attended the deceased from <u>July</u> , 19 <u>64</u> , to <u>Nov</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>Nov 29 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) <u>(we)</u> <u>(did not)</u> view the body after death.						
22b. SIGNATURE <i>Riccardo U. FRANCHI</i>		DEGREE ATTENDING PHYS	<input checked="" type="checkbox"/> MED DIRECTOR	<input type="checkbox"/> STAFF PHYS.	22c. DATE SIGNED <u>11-29-68</u>	
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS				
Riccardo U. FRANCHI		7729 Finns Lane, Lanham Md				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>12/4/68</u>	23c. NAME OF CEMETERY OR CREMATORIAL <u>Reading Cemetery</u>	23d. LOCATION (City or Town) <u>Reading</u>	(County) <u>Kansas</u>	(State)
24. FUNERAL DIRECTOR <u>M. A. Dugall</u>		ADDRESS <u>M. A. Dugall</u>	25a. REC'D BY REGISTRAR <u>DEC 5 1968</u>	25b. REGISTRAR'S SIGNATURE <u>W. Clemons Judge</u>		
Warner E. Lumpkin Inc.		8434 Ga. Ave. S.S., Md.				



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if necessary, please execute the certificate, writing the word "pending" in pencil in Item 1a. If you have any delay in filing the certificate, file pages 1, 2 and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO MEDICAL DIRECTOR: Page 3 should be signed by the funeral director, or removal, and in any event within 72 hours after death. He or she prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH  
16358 DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. DECEASED NAME (Type or Print)		First	Middle	Last	20. DATE KNOWN <input checked="" type="checkbox"/> Month Day Year	2b. HOUR
		Margaret		Johnson	11-25-68 19:30am M	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (in years last birthday)	F UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS HOURS MIN	2d. HOUR
Female	Negro	7-27-1922	46 yrs			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		9. COUNTY OF DEATH
Md		U.S.A.		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		Prince George's Md
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USLA. OCCUPATION (Kind of work done during most of working life, even if retired)	
Cheverly		Prince George Hospital			12b. KND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution residence before admission)		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS		13e. STREET AND NUMBER
STATE Maryland		13b. COUNTY Prince George's Beltsville		YES <input type="checkbox"/> NO <input type="checkbox"/>		11907 Ellington Drive
14. FATHER'S NAME		First	Middle	Last	15. MOTHER'S MAIDEN NAME	First
Richard Thomas					Maggie Matthews	Middle
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO		17. INFORMANT		ADDRESS
No		-		William Thomas		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)						
PART I. DEATH WAS CAUSED BY:						
IMMEDIATE CAUSE (a) <u>Multiple gun shot wounds of chest</u>						
DUE TO, OR AS A CONSEQUENCE OF						
Conditions, if any, which gave rise to immediate cause (a). (b)						
stating the underlying cause lost.						
DUE TO, OR AS A CONSEQUENCE OF						
(c)						
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH						
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY?	
19c. MEDICAL CERTIFICATION					YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M.		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b)		
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) home		21f. LOCATION Street or R.F.D. No		City or Town County State
Shot during altercation same as # 13						
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input checked="" type="checkbox"/> , Undetermined manner <input type="checkbox"/>						
ACTUAL SIGNATURE		John Kehoe MD			CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type)		Riverdale, Md.			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
23a. BURIAL CREMATION REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS		23d. LOCATION (City or Town) (County) (State)
11-30-68		Queens Chapel		Hawthorne Md		
24. FUNERAL DIRECTOR		ADDRESS		25a. RECEIVED BY REGISTRAR		25b. REGISTRAR'S SIGNATURE
H.S. Washington & Son 4925 Berne Ave SE				DEC 2 1968		Charles Judge

88

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
CERTIFICATE OF DEATH

**HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

**FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please mail via carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, or in any event, within 72 hours after death.

16359		16359							
1. DECEASED-NAME (Type or print)		First  <b>Esther</b>	Middle  <b>M.</b>	Last  <b>Jones</b>	2d. DATE OF DEATH Month <b>Nov.</b> Day <b>26, 1968</b>	2b. HOUR Year <b>1:50AM</b>			
3. SEX  <b>Female</b>		4. RACE  <b>Negroid</b>		S. DATE OF BIRTH  <b>May 20, 1922</b>	6. AGE (in years lost birthday) <b>46</b> YRS.		IF UNDER 1 YEAR MONTHS <b>0</b>	IF UNDER 24 HRS HOURS <b>0</b>	MIN <b>0</b>
7a. BIRTHPLACE (State or foreign country)  <b>DC</b>		7b. CITIZEN OF WHAT COUNTRY?  <b>U.S.A.</b>		B. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> SEPARRSED <input type="checkbox"/>	9. COUNTY OF DEATH  <b>Prince George's</b>				
10. CITY OR TOWN OF DEATH  <b>Cheverly</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)  <b>Prince Geo. Gen'l Hospital</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)  <b>Teacher</b>		12b. KIND OF BUSINESS OR INDUSTRY  <b>Wash. D.C.</b>			
13a. RESIDENCE (Where deceased lived, if institution Residence before admission) STATE  <b>Maryland</b>		13c. CITY OR TOWN  <b>Prince George's</b>		3d. INSIDE CITY BM-TS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER  <b>6108 K Street</b>				
14. FATHER'S NAME First  <b>Byron McNeil</b>		Middle  <b></b>	Last  <b></b>	15. MOTHER'S MAIDEN NAME First  <b>Sylvia Doctor</b>		Middle  <b></b>	Last		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown  <b>No</b>		16b. SOCIAL SECURITY NO.  <b>None</b>		17. INFORMANT  <b>Johnny B Jones 2643 Bowen Rose</b>		Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Arrest.</u>  <b>4100</b> Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause  <b></b>		18b. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
(b) <u>Hypertensive Cardiovascular disease.</u> DUE TO, OR AS A CONSEQUENCE OF  DUE TO, OR AS A CONSEQUENCE OF (c) <u>Cerebral Arteriosclerosis, severe.</u>									
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(c)  <b>773X</b> <b>Cerebral edema.</b>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?  <b>Yes</b>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>Nov. 24, 1968</b> , to <b>Nov. 26, 1968</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>Nov. 26, 1968</b> , and that <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) did <input checked="" type="checkbox"/> view the body after death.									
22b. SIGNATURE  <b>Dr. S.V. Nair</b>		DEGREE  <b>MD</b>	ATTENDING PHYS. <input type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input checked="" type="checkbox"/>	22c. DATE SIGNED  <b>Nov. 26, 1968</b>			
22d. PHYSICIAN'S NAME (Type)  <b>S.V. Nair, M. D.</b>		22e. ADDRESS  <b>Prince Geo. Gen'l Hospital, Cheverly, Md.</b>							
23a. BURIAL CREMATION, REMOVAL (Specify)  <b>11-29-68</b>		23c. NAME OF CEMETERY OR CREMATORIUM  <b>Harmony</b>		23d. LOCATION (City or Town) (County) (State)  <b>Highland Park Md</b>					
24. FUNERAL DIRECTOR  <b>Charles Judge</b>		ADDRESS  <b>4935 11th and 22nd St Washington D.C.</b>		25a. REC'D BY REGISTRAR DATE <b>DEC 2 1968</b>		25b. REGISTRAR'S SIGNATURE  <b>Charles Judge</b>			

644

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
**CERTIFICATE OF DEATH**

16360

16360

**10 HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers 1 and 2 and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
45M - 1/69

1 DECEASED-NAME (Type or print)		First <b>Helen</b>	Middle <b>M.</b>	Last <b>Jones</b>	2d. DATE OF DEATH Month <b>Nov.</b>	Day <b>25,</b>	Year <b>1968</b>	2d. HOUR <b>1:10AM</b>
3. SEX <b>Female</b>	4. RACE <b>Negroid</b>	5. DATE OF BIRTH <b>Jan. 11, 1903</b>		6. AGE (In years last birthday) <b>65</b>	IF UNDER 1 YEAR MONTHS <b>YRS.</b>	IF UNDER 24 HRS DAYS <b>0</b>	IF UNDER 24 HRS HOURS <b>0</b>	IF UNDER 24 HRS MIN <b>0</b>
7a BIRTHPLACE (State or foreign country) <b>Maryland</b>	7b CITIZEN OF WHAT COUNTRY? <b>USA</b>	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Prince George's</b>				
10. CITY OR TOWN OF DEATH <b>Cheverly</b>	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Prince Geo. Gen'l Hospital</b>		12a. U.S.A. OCCUPATION (Kind of work done during most of working life, even if retired) <b>Domestic</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Md</b>			
13a USUAL RESIDENCE (Where deceased lived, if institution or residence before admission) STATE <b>Maryland</b>	13b COUNTY <b>Prince George's</b>	13c CITY OR TOWN <b>St. Pleasant</b>	13d INSIDE CITY LIMITS? <b>YES <input type="checkbox"/> NO <input type="checkbox"/></b>	13e STREET AND NUMBER <b>7281 Kolb Street</b>				
14. FATHER'S NAME First <b>William</b>	Middle <b>Jones</b>	Last	15. MOTHER'S MAIDEN NAME First <b>Mary</b>	Middle <b>Brown</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <b>Yes</b>	16b SOCIAL SECURITY NO. (If yes give war or dates of service)	17 INFORMANT <b>Sister</b>	Address <b>Mrs. Margaret Smith-7281 Kolb St</b>					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Diffused Carcinomatosis.</b>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
1992 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>Pneumonia, right lung.</b>							DUE TO, OR AS A CONSEQUENCE OF	
DUE TO, OR AS A CONSEQUENCE OF (c)								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)								
20a. DATE OF OPERATION		20b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20c. AUTOPSY? <b>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></b>	20d. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>Yes</b>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18)					
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, FARM, STREETS, FACTORY OFFICE BUILDING, ETC)	21f LOCATION Street or R.F.D. No	City or Town	County	State		
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>Nov. 4, 1968</b> to <b>Nov. 25, 1968</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>Nov. 25, 1968</b> , and that <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) (did) <input checked="" type="checkbox"/> view the body after death.								
22b. SIGNATURE <i>Arnold G. Brody, M.D.</i>		DEGREE <b>MD</b>	ATTENDING PHYS. <input type="checkbox"/>	MED DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input checked="" type="checkbox"/>	22c. DATE SIGNED <b>Nov. 25, 1968</b>		
22d. PHYSICIAN'S NAME (Type) <b>Arnold G. Brody, M. D.</b>		22e ADDRESS <b>Prince Geo. Gen'l Hospital, Cheverly, Md.</b>						
23a. BURIAL, CREMATION REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>11/29/68</b>	23c. NAME OF CEMETERY OR CREMATORIUM <b>Mt. Olivet Cemetery</b>		23d. LOCATION (City or Town) <b>Washington, D.C.</b>	(County)	(State)		
24. FUNERAL DIRECTOR <b>John T. Stewart Jr.</b>	ADDRESS <b>Funeral Home-4001 Benning Road</b>	25a. REC'D BY REG STRR <b>DAN</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>				



MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

16361 16370

1.

2.

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.  
 Page 4 may be retained by the hospital or attending physician.  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print)		First <b>RICHARD</b>	Middle <b>P</b>	Lost <b>JONES</b>	2d. DATE OF DEATH Month <b>NOV</b>	Day <b>13</b>	Year <b>68</b>	2d. HOUR <b>2350</b>
3. SEX		4. RACE <b>MALE</b>	5. DATE OF BIRTH <b>18 JUN 65</b>	6. AGE (In years lost birthday) <b>3 YRS.</b>		IF UNDER 1 YEAR MONTHS <b>0</b>	IF UNDER 24 HRS. HOURS <b>0</b>	2b. HOUR MIN. <b>00</b>
7a. BIRTHPLACE (State or foreign country) <b>TEXAS</b>		7b. CITIZEN OF WHAT COUNTRY? <b>UNITED STATES</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	9. COUNTY OF DEATH <b>PRINCE GEORGE</b>				
10. CITY OR TOWN OF DEATH <b>CAMP SPRINGS, MD</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>MALCOLM GROW USAF HOSP</b>	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>DEPENDENT</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>NONE</b>			
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <b>MARYLAND</b>		13c. CITY OR TOWN <b>PRINCE GEORGE</b>	13d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	13e. STREET AND NUMBER <b>4254-1 DOGWOOD LANE</b>				
14. FATHER'S NAME First <b>WILLIAM</b>		Middle <b>W</b>	Last <b>JONES</b>	15. MOTHER'S MAIDEN NAME First <b>EMMA L.</b>		Middle <b>L</b>	Last <b>TOBIAS</b>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <b>NO</b>		16b. SOCIAL SECURITY NO <b>NONE</b>	17. INFORMANT <b>WILLIAM W JONES</b>	Address <b>4254-1 DOGWOOD LANE</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 WEEK</b>		
<p>18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))  <b>PART I DEATH WAS CAUSED BY</b>  <b>IMMEDIATE CAUSE (a)</b> <b>PNEUMONIA</b>    <b>DUE TO, OR AS A CONSEQUENCE OF</b>  <b>(b) SPASTIC CEREBRAL PALSY WITH MENTAL RETARDATION</b>  <b>DUE TO, OR AS A CONSEQUENCE OF</b> <b>&amp; SEIZURE DISORDER.</b>  <b>(c)</b></p>								
<p>19. PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)</p>								
19a. MEDICAL CERTIFICATION DATE OF OPERATION <b>6 NOV 68</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>BALANITIS- CIRCUMCISION</b>		20a. AUTOPSY? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. City or Town County State					
<p>22a. I certify that <input type="checkbox"/> (this hospital) attended the deceased from <b>10 NOV</b>, 19<b>68</b>, to <b>13 NOV</b>, 19<b>68</b>, that <input checked="" type="checkbox"/> (I) <input type="checkbox"/> last saw the deceased alive on <b>13 NOV</b>, 19<b>68</b>, and that in <b>(my) <input type="checkbox"/></b> opinion death occurred on the date and hour and from the causes stated above, <b>(I) <input type="checkbox"/> (did) <input checked="" type="checkbox"/> (did not) view the body after death.</b></p>								
22b. SIGNATURE <i>Kenneth A Bradford, M.D.</i>		22c. DEGREE <b>D.E.C.</b>	ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	22d. DATE SIGNED <b>13 NOV 68</b>		
22e. PHYSICIAN'S NAME (Type) <b>KENNETH A BRADFORD, CAPT, USAF</b>		22f. ADDRESS <b>MALCOLM GROW USAF HOSP, ANDREWS AFB MD</b>						
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>11-18-68</b>	23c. NAME OF CEMETERY OR CREMATORIAL <b>Arlington National</b>	23d. LOCATION (City or Town) <b>Arlington, Virginia</b>	(County) (State)			
24. FUNERAL DIRECTOR <b>W. W. Chambers 6-517-115 St. S.E.</b>		ADDRESS	25a. REC'D BY REGISTRAR <b>NOV 18 1968</b>		25b. REGISTRAR'S SIGNATURE <i>Charles J. Jones</i>			
VR A15 (4) 30M REV. 1/68								



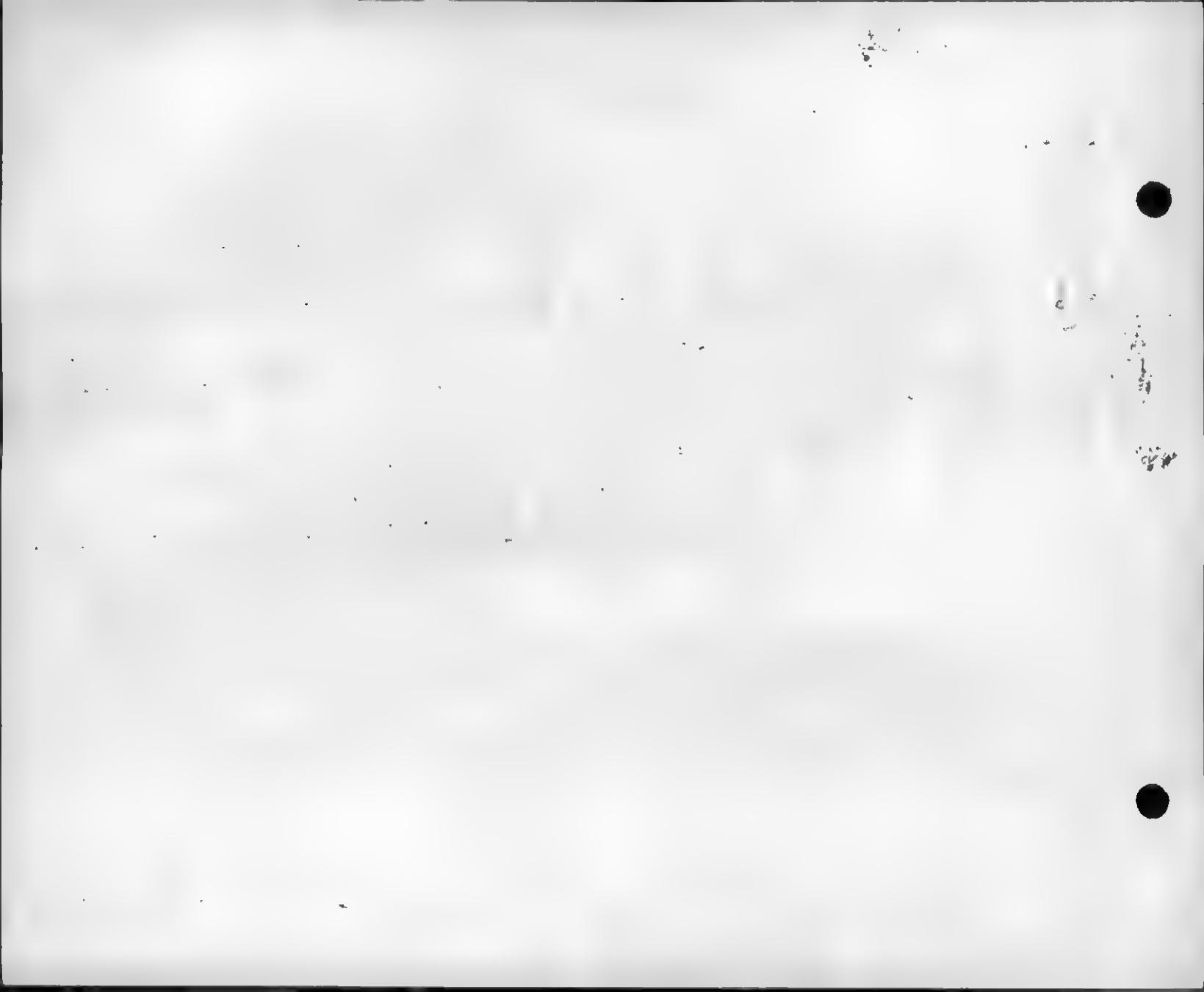
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
CERTIFICATE OF DEATH

16362 10376

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove it from paper and file it with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours of death.

1. DECEASED-NAME (Type or print)				First <i>William</i>	Middle <i>Richard</i>	Last <i>Jones</i>	2a. DATE OF DEATH Month <i>NOV</i>	Day <i>28</i>	Year <i>66</i>	2b. HOUR 10:47PM		
3. SEX Male		4. RACE Caucasian		5. DATE OF BIRTH 11/05/93			6. AGE (In years last birthday) <i>75</i> YRS.		7. IF UNDER 1 YEAR MONTHS DAYS		8. IF UNDER 24 HRS HOURS MIN	
7a BIRTHPLACE (State or foreign country) <i>PENNA</i>		7b CITIZEN OF WHAT COUNTRY? <i>U.S.</i>		8 MARRIED <input type="checkbox"/> NEVER MARR ED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH <i>Prince George's</i>					
10 CITY OR TOWN OF DEATH <i>Cheverly</i>		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Prince Geo. General</i>			12a USUAL OCCUPATION (Kind of work done during most of work life, even if retired) <i>BOOK BINDER</i>			12b KIND OF BUSINESS OR INDUSTRY <i>Ma</i>				
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <i>Maryland</i>		13b. COUNTY <i>Prince George's</i>		13c. CITY OR TOWN <i>Riverdale</i>		13d. INSIDE CITY LIMIT? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		13e. STREET AND NUMBER <i>4713 Oliver Street</i>				
14. FATHER'S NAME First <i>WILLIAM R.</i>		Middle <i>JONES</i>	Last	15. MOTHER'S MAIDEN NAME First <i>UNKNOWN</i>								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <i>No</i>		16b. SOCIAL SECURITY NO. <i>220-40-5992</i>		17. INFORMANT <i>ROBERT C. JONES</i>			18. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>8518 CUNNINGHAM AV BERWYN HEIGHTS, MARYLAND</i>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Ruptured Arteriosclerotic aneurysm of the</i> due to, or as a consequence of <i>Abdominal Aorta with massive right</i> Conditions, if any, which gave <i>retro-peritoneal hemorrhage, 2. Arteriosclerotic</i> rise to immediate cause (a), <i>retroperitoneal heart disease, severe with extensive</i> stating the underlying cause <i>myocardial fibrillation, generalized arterosclerosis, severe</i> last (b) <i>Arteriosclerotic</i> due to, or as a consequence of <i>retroperitoneal heart disease, severe with extensive</i> (c) <i>Myocardial Fibrillation, Generalized Arterosclerosis, severe</i>												
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION LISTED IN PART I(a) <i>451 X</i>												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or RFD No. <i>2573 Bucklodge Rd.</i>		City or Town <i>Riverdale, Md.</i>		County <i>Maryland</i>	State <i>MD</i>			
22a. I certify that (I) (husband) attended the deceased from <i>11-26-66</i> , to <i>11-26-66</i> , that (I) <input type="checkbox"/> lost saw the deceased alive on <i>11-26-66</i> , and that in my ( <i>our</i> ) opinion death occurred on the date and hour and from the causes stated above, (I) <input type="checkbox"/> (we) <input type="checkbox"/> (did) <input type="checkbox"/> view the body after death.												
22b. SIGNATURE <i>R.D. Banet, M.D.</i>		22c. DEGREE ATTENDING PHYS		<input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS		22d. DATE SIGNED <i>11-26-66</i>						
22d. PHYSICIAN'S NAME (Type) <i>R.D. Banet, M.D.</i>		22e. ADDRESS <i>2573 Bucklodge Rd., Riverdale, Md.</i>										
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>		23b. DATE <i>11-30-1968</i>		23c. NAME OF CEMETERY OR CREMATORIAL <i>CEDAR HILL CEMETERY</i>			23d. LOCATION (City or Town) (County) (State) <i>SUITLAND, MARYLAND</i>					
24. FUNERAL DIRECTOR <i>J.W. Chambers Co. Riverdale, Md.</i>		ADDRESS			25a. RECEIVED BY REGISTRAR <i>DEC 5 1968</i>			25b. REGISTRAR'S SIGNATURE <i>Charles J. S. G.</i>				

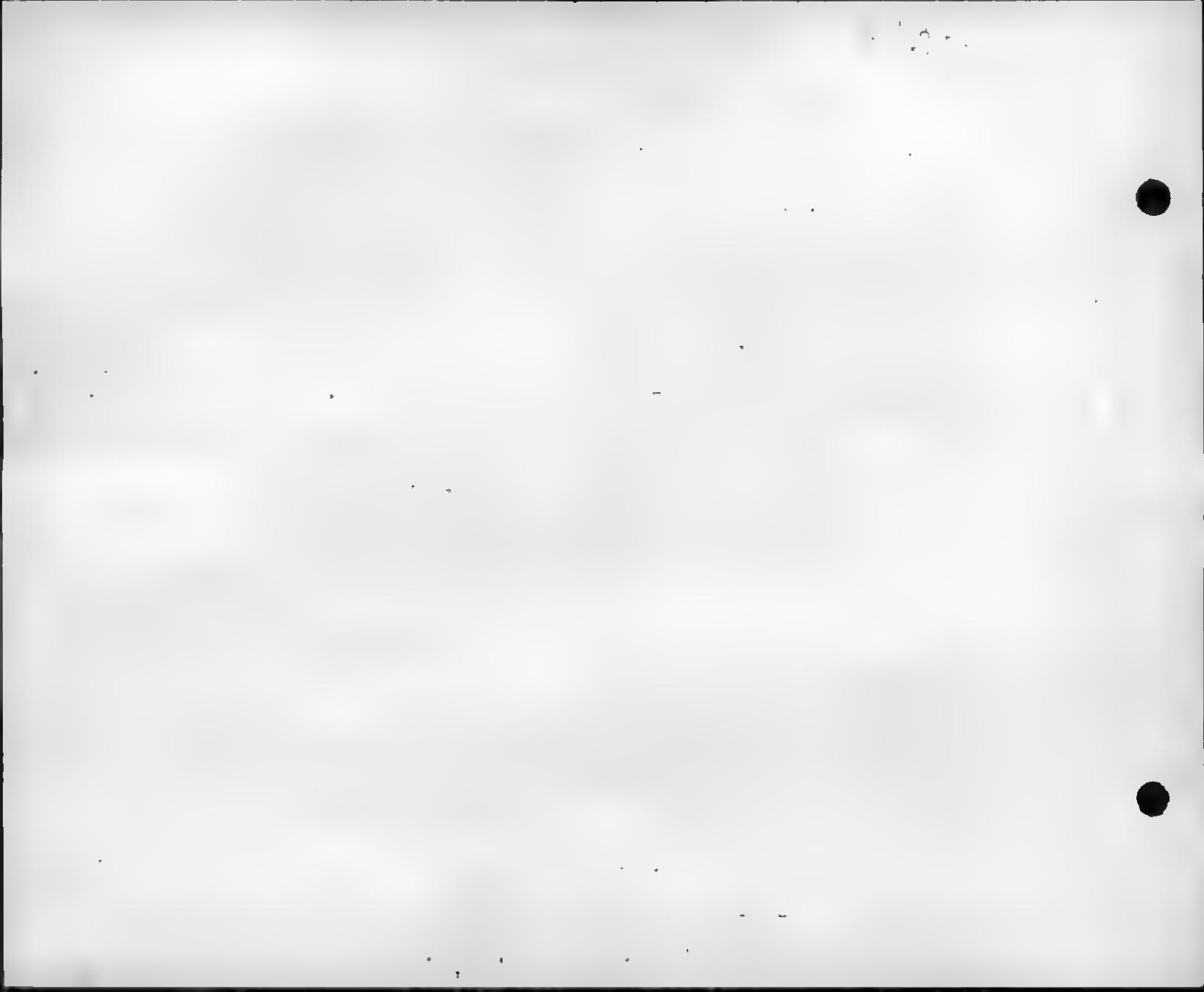


MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
CERTIFICATE OF DEATH

**10 HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.  
**Page 4 may be retained by the hospital or attending physician.**

**10 FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. **Page 1 and 2** should be filed with the State Dept. of Health prior to burial, cremation, or removal, and **page 4** should be filed within 72 hours after death.

1 DECEASED-NAME (Type or print)		First <b>Daniel</b>	Middle <b>G.</b>	Last <b>Joseph</b>	2a DATE OF DEATH Month <b>Nov.</b> <b>26,</b> <b>1968</b> Day Year	2b HOUR <b>A.</b> <b>12:30 M.</b>
3 SEX <b>Male</b>	4 RACE <b>Caucasian</b>	5 DATE OF BIRTH <b>April 15, 1906</b>		6 AGE (in years last birthday) <b>62</b>	7 IF UNDER 24 HRS MONTHS <b>YRS</b>	8 IF UNDER 24 HRS HOURS <b>M.M.</b>
7a BIRTHPLACE (State or foreign (country)) <b>Washington D.C.</b>	7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	B. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9 COUNTY OF DEATH <b>Prince George's</b>	Md	
10 CITY OR TOWN OF DEATH <b>Cheverly</b>	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Prince Geo. General Hosp.</b>		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)	12b KIND OF BUSINESS OR INDSTRY		
13a USUAL RESIDENCE (Where deceased lived, if institution Res dence before admission) <b>Maryland</b>	13b COUNTY <b>Prince George's</b>	13c CITY OR TOWN <b>Seat Pleasant</b>	13d INSIDE CITY <input type="checkbox"/> OUTSIDE <input checked="" type="checkbox"/>	13e. STREET AND NUMBER <b>300 Addison Road</b>		
14 FATHER'S NAME <b>Daniel</b>	First <b>G.</b>	Middle <b></b>	Last <b>Joseph Sr.</b>	MOTHER'S MAIDEN NAME First <b>Mary</b>	Middle <b></b>	Last <b>Mussante</b>
.6a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <b>No</b>	16b SOCIAL SECURITY NO <b>577-05-4260</b>		17 INFORMANT <b>Mrs. Helen P. Joseph</b>	Address <b>2811 So. Ari.</b>		
M. Joseph Ridge Rd. Ari Va						
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))						
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac Arrest. Acute Myocardiac Infarction</b>						
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic Heart Disease.</b>						
DUE TO, OR AS A CONSEQUENCE OF (c)						
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (g)						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO <b>XX</b>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>	21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME FARM STREET, FACTORY OFFICE BUILDING, ETC.)	21f LOCATION Street or R.P.D. No.	City or Town	County	State
22a. I certify that (I) (this hospital) attended the deceased from <b>Nov. 18</b> , <b>1968</b> , to <b>Nov. 26</b> , <b>1968</b> , that (I) (we) last saw the deceased alive on <b>Nov. 26</b> , <b>1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death						
22b. SIGNATURE <i>W. Hernandez</i>		DEGREE <b>MD</b>	ATTENDING PHYS <input checked="" type="checkbox"/>	MED DIRECTOR <input type="checkbox"/>	STAFF PHYS <input checked="" type="checkbox"/>	22c. DATE SIGNED <b>11/27/68</b>
22d. PHYSICIAN'S NAME (Type) <b>Tomas Hernandez, M.D.</b>		22e ADDRESS <b>3308 Dodge Park Rd., Landover, Md.</b>				
23a BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b DATE <b>11-29-68</b>	23c NAME OF CEMETERY OR CREMATORIAL <b>Cedar Hill Cemetery</b>		23d LOCATION (City or Town) <b>Suitland</b> (County) <b>Maryland</b> (State)		
24. FUNERAL DIRECTOR <i>J. E. Eareley</i>		ADDRESS <b>1500 W. Brad. Rd. Alex Va.</b>	25a. REC'D BY REGISTRAR <b>DEC 2 1968</b>	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		



**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed ~~within~~ 24 hours after death.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers and 2 copies and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours of death.

16364

**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201**

1637.

1. DECEASED NAME (Type or print)		First	Middle	Lost	2d. DATE OF DEATH Month	Year	2b. HOUR 9:15
Emma		L.	Juenemann		Nov.	17	
3. SEX Female	4 RACE White	5. DATE OF BIRTH Dec. 13, 1889			6. AGE (In years last birthday) 78	IF UNDER 1 YEAR MONTHS	IF UNDER 24 HRS. HOURS
7b. BIRTHPLACE (State or foreign country) Wash. D. C.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED WIDOWED	NEVER MARRIED DIVORCED	9. COUNTY OF DEATH Prince George	
10. CITY OR TOWN OF DEATH Hyattsville		11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) Academy Heart Home			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Housewife		12b. KIND OF BUSINESS OR INDUSTRY
13a. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) STATE Md.		13c. CITY OR TOWN Charles		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER Star Rt. 2		
14. FATHER'S NAME Adolph Jouvenal		15. MOTHER'S MAIDEN NAME Carrie V. Whitemore					Last
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <input checked="" type="checkbox"/>		16b. SOCIAL SECURITY NO. 577-05-4078		17. INFORMANT Lois M. Isham			Address Star Rt. 2 PaPlata, Md.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a)		Congestive Failure			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 months		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last		Arteriosclerotic Heart Disease with DUE TO, OR AS A CONSEQUENCE OF (b) Diabetes Mellitus DUE TO, OR AS A CONSEQUENCE OF (c)			1/24/65		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.	City or Town	County	State
22a. I certify that (I) <input type="checkbox"/> attended the deceased from 1/24, 1965, to 11/16, 1968, that (I) <input type="checkbox"/> last saw the deceased alive on Nov. 16 1968 and that in (my) <input type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above, (I) <input type="checkbox"/> (we) <input type="checkbox"/> (did) <input type="checkbox"/> view the body after death.							
22b. SIGNATURE Thomas F. Collins		DEGREE	ATTENDING PHYS	MED DIRECTOR	STAFF PHYS.	22c. DATE SIGNED Nov. 18, 1968	
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS 2600 Queens Chapel Road					
Thomas F. Collins, M.D.							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 11-21-68	23c. NAME OF CEMETERY OR CREMATORIUM Cedar Hill Cemetery		23d. LOCATION (City or Town) Suitland		(County) Pr. Geo. (State) Md.
24. FUNERAL DIRECTOR Wilhelm Funeral Home 4308 Suitland Rd. S. E.		ADDRESS NOV 21 1968		25d. REGISTRAR'S SIGNATURE Thomas F. Collins			



## MARYLAND STATE DEPARTMENT OF HEALTH

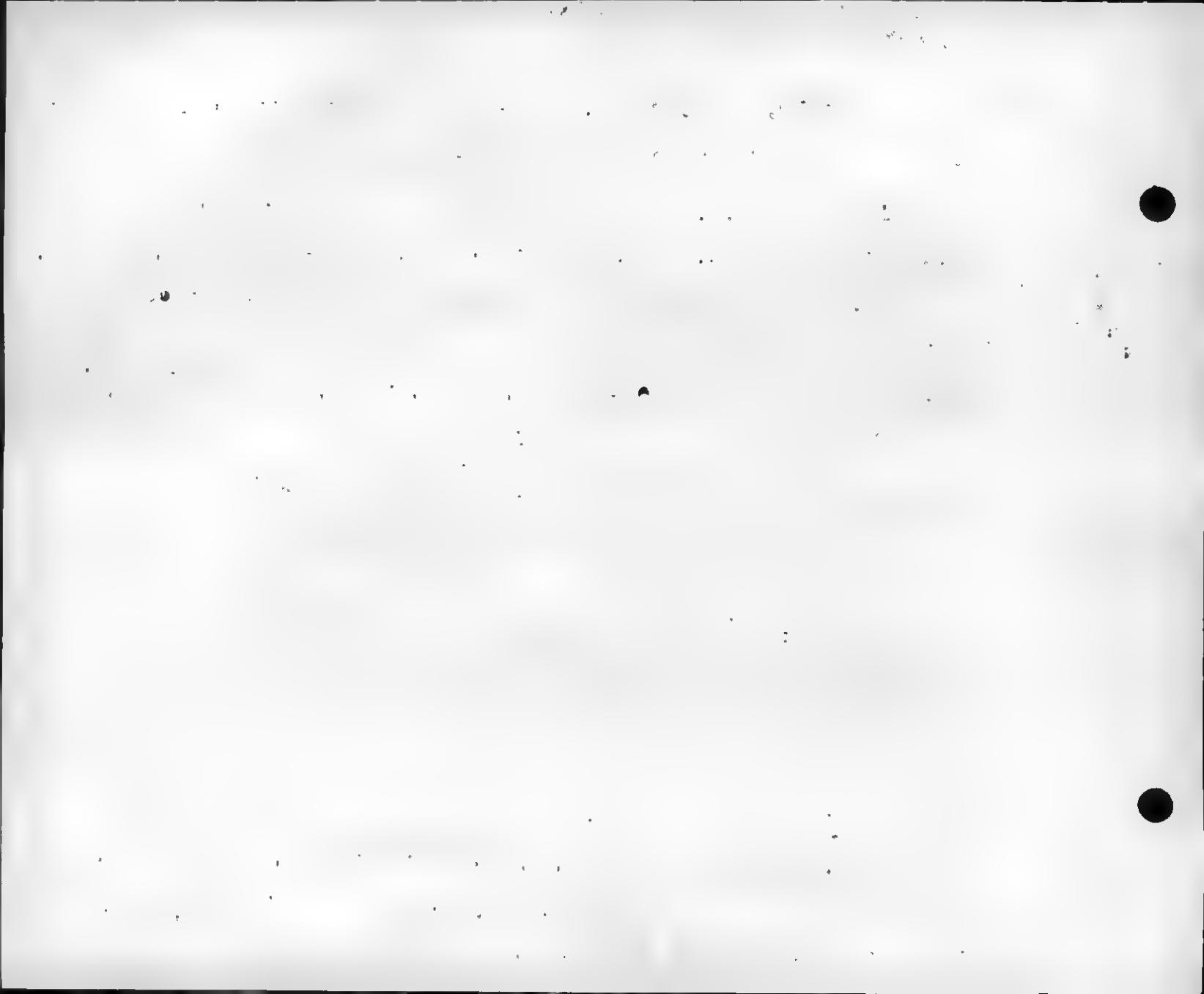
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
CERTIFICATE OF DEATH

1057

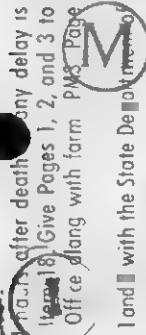
10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.  
10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician or completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print)	First <b>XKASER</b>	Middle <b>George C.</b>	Last <b>Kaiser</b>	2a. DATE OF DEATH Month <b>November</b>	Day <b>9</b>	Year <b>1968</b>	2b. HOUR <b>10:40</b>		
3. SEX Male	4. RACE Caucasian	S. DATE OF BIRTH <b>9-28-94</b>	6. AGE (In years last birthday) <b>74</b>	IF UNDER 1 YEAR MONTHS <b>YRS.</b>	IF UNDER 24 HRS HOURS <b>00</b>	MIN. <b>00</b>			
7a. BIRTHPLACE (State or foreign country) <b>Maryland</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	9. COUNTY OF DEATH <b>Prince Georges</b>	Md.					
10. CITY OR TOWN OF DEATH <b>Riverdale</b>	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>E. Leland Memorial</b>	12a. USUAL OCCUPATION (Kind of work done during most of working time, even if retired) <b>Retired Foreman</b>	12b. KIND OF BUSINESS OR INDUSTRY <b>Beth. Steel Co.</b>						
13a. US. RESIDENCE (Where deceased lived, if institution, Residence before admission) STATE <b>Md.</b>	13b. COUNTY <b>Baltimore</b>	13c. CITY OR TOWN <b>Sparrows Point</b>	13d. INSIDE CITY LIMITS? <b>YES</b>	13e. STREET AND NUMBER <b>511 F. Street</b>					
14. FATHER'S NAME First <b>John</b>	Middle <b>Kaiser</b>	Last	15. MOTHER'S MAIDEN NAME First <b>Lillian</b>	Middle	Last <b>Willy</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <b>Yes</b>	16b. SOCIAL SECURITY NO. <b>213-07-8732</b>	17. INFORMANT (Son) <b>Mr. John R. Kaiser, 4708 Edgewood Rd.</b>	Address <b>College Pk. Md.</b>						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <b>Myocardial failure</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause <b>hypertension</b> stating the underlying cause <b>recent</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>unrecorded</b>							
(b) <b>Aspirate pulmonary arterial embolus</b> DUE TO, OR AS A CONSEQUENCE OF (c)									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(c)									
19a. DATE OF OPERATION <b>10-17-68</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>cholecystitis, lithiasis</b>	20a. AUTOPSY? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>Yes</b>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from <b>10-12</b> , 19 <b>65</b> , to <b>11-9</b> , 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>11-4</b> , 19 <b>68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								22c. DATE SIGNED <b>11/9/68</b>	
22b. SIGNATURE <b>D. R. Purdie, M.D.</b>		ATTENDING PHYS <input type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input checked="" type="checkbox"/>					
22d. PHYSICIAN'S NAME (Type) <b>D. R. Purdie</b>		22e. ADDRESS <b>E. Leland Hospital, Riverdale, Md.</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>11/13/68</b>	23c. NAME OF CEMETERY OR CREMATORIAL <b>Meadowridge Memorial Park</b>	23d. LOCATION (City or Town) <b>Dorsey, Maryland</b>	(County) <b></b>	(State) <b></b>			
24. FUNERAL DIRECTOR <b>John J. Duda, 7922 Wise Ave. Dundalk, Md.</b>		ADDRESS	25a. REC'D BY REGISTRAR <b>NOV 15 1968</b>	25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>					



**FOR STATE  
HEALTH DEPT.**



16368  
16368  
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is  
necessary, please execute the certificate, writing the word "pending" in pencil. Give Pages 1, 2, and 3 to  
the funeral director. Page 4 should be forwarded to the Chief Medical Examiner. Office along with form PWS Page  
5 may be retained for your files.  
  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit file along with the State Death  
Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH														
1 DECEASED NAME (Type or Print)		First		Middle		Last		2a DATE KNOWN OF ESTI- DEATH MATED		Month	Day	Year	2b HOUR	
Paul		B		Keener				<input checked="" type="checkbox"/> 11-13-68		195:35	am	mm	35 am	
3 SEX	4 RACE	5 DATE OF BIRTH		6 AGE (In years last birthday)		7 F UNDER 1 YEAR		8 F UNDER 24 HRS					2d HOUR	
Male	White	2-5-1911		57 yrs		DAYS		HOURS						
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED		<input checked="" type="checkbox"/> NEVER MARRIED		<input type="checkbox"/>		9. COUNTY OF DEATH				
West Va		U S A		<input checked="" type="checkbox"/> WIDOWED		<input type="checkbox"/> DIVORCED		<input type="checkbox"/>		Prince George's			Md	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b KIND OF BUSINESS OR INDUSTRY								
Cheverly		Prince George Hospital		Chief engineer		Hospital								
13a USUAL RESIDENCE (Where deceased lived, if institution Reside before admission) STATE		13c CITY OR TOWN		13d INSIDE CITY LIMITS?		13e STREET AND NUMBER								
Maryland		Prince George's Bladensburg		<input type="checkbox"/> YES		5000 Townsend Way								
14. FATHER'S NAME		First		Middle		Last		15. MOTHER'S MAIDEN NAME		First		Middle		Last
		Bernard R Keener						Daisy Sprigston						
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or Unknown)		(If yes give war or dates of service)		16b SOCIAL SECURITY NO		17 INFORMANT		ADDRESS						
yes		W W II		234 14 2254		Mary Ellen Keener		Bladensburg,		Md.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart failure												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH minutes		
DO TO, OR AS A CONSEQUENCE OF Arteriosclerotic heart disease												over 4 yrs.		
Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause		(b)		(c)		DUE TO, OR AS A CONSEQUENCE OF								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)														
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		19c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)		20. AUTOPSY?								
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b TIME OF INJURY Month, Day, Year HOUR A.M. PM		21c LOCATION Street or R.F.D. No		20. AUTOPSY?								
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f CITY OR TOWN		COUNTY		STATE						
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>												22b. DATE SIGNED		
ACTUAL SIGNATURE		John Kehoe MD		Riverdale, Md.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>								
EXAMINER'S NAME (Type)						ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>								
						DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>								
						ADDRESS (Street, city, town, or county)								
23a BURIAL CREMATION REMOVAL (Specify)		23b DATE		23c. NAME OF CEMETERY OR CREMATORIUM		23d LOCATION (City or Town)		(County)		(State)				
Burial		Nov 16, 1968		Mt Olive Baptist Cemetery		Salem Doddridge		West Va						
24 FUNERAL DIRECTOR		ADDRESS		25a REC'D BY REG STRAR		25b REG STRAR'S SIGNATURE								
		F. Gasch's Sons Hyattsville, Md.				DATE NOV 18 1968						Charles Judge		



**HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

**FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 4 may be retained by the hospital or attending physician. This certificate, page 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours of death.

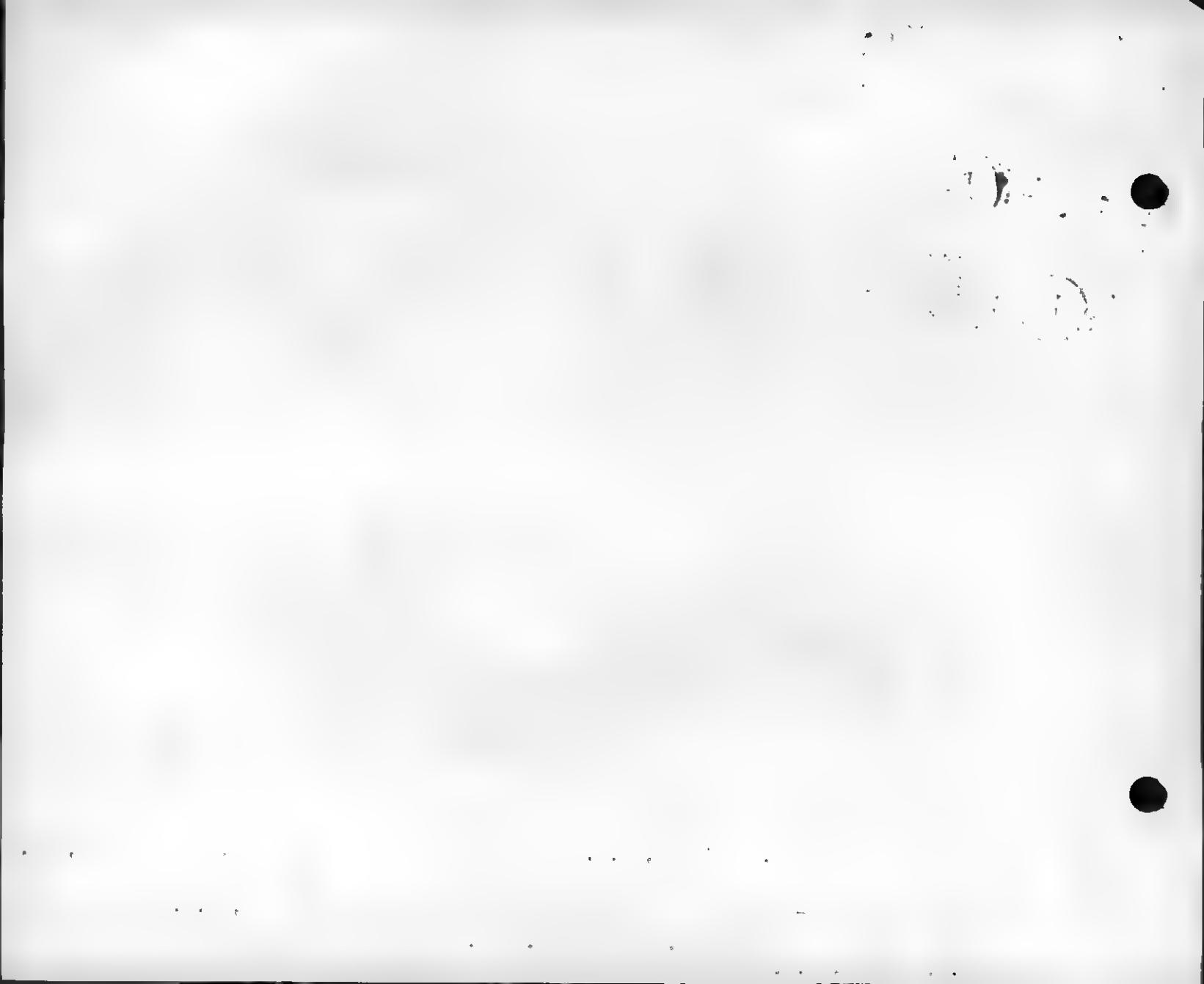
16367

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16367

## CERTIFICATE OF DEATH

1. DECEASED NAME (Type or print)	First <i>Crosby</i>	Middle	Last <i>Kelly</i>	2d. DATE OF DEATH Month <i>11</i> - Day <i>30</i> - Year <i>68</i>	2b. HOUR <i>10:57 AM</i>
3. SEX <i>Male</i>	4. RACE <i>White</i>	5. DATE OF BIRTH <i>11-18-1885</i>	6. AGE (in years last birthday) <i>83</i> YRS	IF UNDER 1 YEAR MONTHS <i>0</i>	IF UNDER 24 HRS. DAYS <i>0</i>
7a. BIRTHPLACE (State or foreign country) <i>Wash. D.C.</i>	7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH <i>Prince Georges</i>	Md.	
10. CITY OR TOWN OF DEATH <i>Banham</i>	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Magnolia Gardens</i>	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>VETERINARIAN</i>	12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUA. RESIDENCE (Where deceased lived, if institutional Residence before admiss on) STATE <i>D.C.</i>	13b. COUNTY <i>WASHINGTON</i>	13c. CITY OR TOWN <i>WASHINGTON</i>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER <i>2924 MILLS AVE. N.E.</i>	
14. FATHER'S NAME First <i>William B.</i>	Middle	Last <i>KELLY</i>	15. MOTHER'S MAIDEN NAME First Middle <i>HALLIE</i>	Last <i>SISSON</i>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <i>No</i>	16b. SOCIAL SECURITY NO. <i>186-1-1861</i>	17. INFORMANT <i>MRS. MARTHA E. SMITH, SISTER,</i>	Address <i>PHIL. PA.</i>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Heart Failure</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last <i>Pneumonia</i>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>1 day</i> <i>1 week</i>		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>Hypertension</i>					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING ETC.)	21f. LOCATION Street or R.F.D. No City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from _____, 1967, to 11-30, 1968, that (I) (we) last saw the deceased alive on 11-30 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <i>Leon R. Levitsky</i>	DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22c. DATE SIGNED <i>11-30-1968</i>			
22d. PHYSICIAN'S NAME (Type) <i>Leon R. Levitsky, M.D.</i>	27e. ADDRESS <i>3408 Rhode Island Ave., Mt. Rainier, Md.</i>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE <i>12-3-1968</i>	23c. NAME OF CEMETERY OR CREMATORIUM <i>Congressional Cemetery</i>	23d. LOCATION (City or Town) <i>Washington, D.C.</i>	(County)	(State)
24. FUNERAL DIRECTOR <i>Joseph Gawler's Sons, Inc., 5130 Wisc. Ave. N.W., Wash., D.C., 20016</i>	ADDRESS	25a. REC'D. BY REGISTRAR <i>DEC 5 1968</i>	25b. REGISTRAR'S SIGNATURE <i>Charles Yerkes</i>		



## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## CERTIFICATE OF DEATH

1633

**10 HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after the deceased has been signed by the attending physician or attending physician's director, page 3, should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 DECEASED NAME (Type or print)	First	Middle	Last	2a. DATE OF DEATH Month	2b. HOUR Hour	
<i>DAISY PEARL KEMPER</i>				11 25 68	4 A.M.	
3. SEX <i>F</i>	4. RACE <i>W</i>	5. DATE OF BIRTH <i>APRIL 2 1908</i>		6. AGE (in years last birthday) <i>60 yrs</i>	IF UNDER 1 YEAR MONTHS GAYS	IF UNDER 24 HRS HOURS MIN
7a. BIRTHPLACE (State or foreign country) <i>VA</i>	7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>PRINCE GEORGE</i>	Md.	
10. CITY OR TOWN OF DEATH <i>LAUREL</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>227 GORMAN AVE</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>HOUSEWIFE</i>	12b. KIND OF BUSINESS OR IND.STRY <i>HOME</i>	
13a. USUAL RESIDENCE (Where deceased lived, if inst tut an Residence before admission) STATE <i>MD</i>	13b. COUNTY <i>PR. GEO</i>	13c. CITY OR TOWN <i>LAUREL</i>	13d. INSIDE CTY LIMITS? <i>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></i>	13e. STREET AND NUMBER <i>227 GORMAN AVE</i>		
14. FATHER'S NAME <i>GRANT</i>	First	Middle	Last	15. MOTHER'S MAIDEN NAME <i>MOLLY McDANIEL</i>	Middle	Last
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, No, or unknown <i>Yes</i>	16b. SOCIAL SECURITY NO. <i>(If yes give war or dates of service)</i>	17. INFORMANT <i>HAROLD KEMPER</i>		Address <i>ABOVE</i>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary Thrombosis</i> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>1 c.d.</i>						
4103 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) <i>Coronary Atherosclerosis</i> 5 yrs						
DUE TO, OR AS A CONSEQUENCE OF (b) <i>Coronary Atherosclerosis</i> 5 yrs						
DUE TO, OR AS A CONSEQUENCE OF (c) <i>Cardiodeclerosis</i> 10 yrs						
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>Chronic Bronchitis</i>						
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not at work <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State	
22a. I certify that (I) (this hospital) attended the deceased from <i>8/17/63</i> to <i>5/16/68</i> , that (I) (we) last saw the deceased alive on <i>11/16/67</i> 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) <input checked="" type="checkbox"/> (did) (did not) view the body after death.						
22b. SIGNATURE <i>J. Warren M.D.</i>	22c. DATE SIGNED <i>11/15/68</i>					
22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE <i>11-27-68</i>	23c. NAME OF CEMETERY OR CREMATORIAL <i>BOWYER CEM.</i>	23d. LOCATION (City or Town) <i>COVINGTON VA</i>	(County)	(State)	
24. FUNERAL DIRECTOR <i>Daniedsan Funeral Home, Laurel MD</i>	ADDRESS	25a. REC'D BY REGISTRAR <i>NOV 29 1968</i>	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			



## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

1538.

## CERTIFICATE OF DEATH

1		16369	20. DATE OF DEATH Month Day Year November 22, 1968	2b HOUR P 11:55M
10 HOSPITAL OR ATTENDING PHYSICIAN: Page 4 may be retained by the hospital or attending physician.				
11 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.				
1. DECEASED NAME (Type or print)	First Doris	Middle D.	Lost King	20. DATE OF DEATH Month Day Year November 22, 1968
2. SEX Female	4. RACE White	S. DATE OF BIRTH 6/9/21	6. AGE (In years lost birthday) 47 YRS	2b HOUR P 11:55M
7a. BIRTHPLACE (State or foreign country) Virginia	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Prince George's	
10. CITY OR TOWN OF DEATH Cheverly	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Prince George's Gen. Hosp.	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) House wife	12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution Residege before admission) STATE Maryland	13b. COUNTY Kentland	13c. CITY OR TOWN Kentland	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER 7317 Forest Road
14. FATHER'S NAME Herman	First W.	Middle Balderson	15. MOTHER'S MAIDEN NAME First Nattie	Middle Greenwell
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No	16b. SOCIAL SECURITY NO. (If yes give war or dates of service)	17. INFORMANT Raymond L King Sr	Address Kentla 7317 Forest Rd Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory failure</u> 485X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (last)  (b) <u>Bronchopneumia</u> Due to, or as a consequence of  (c) <u>Chronic bronchopneumonia</u>				
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) 491x Endocarditis				
19a. MEDICAL CERTIFICATION DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)		
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)	21f. LOCATION Street or RFD No.	City or Town	County
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from Oct. 30, 1968, to Nov. 22, 1968, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on November 22, 1968, and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) did <input checked="" type="checkbox"/> (not) view the body after death.	22b. SIGNATURE Fidel J. Quin-Towd			
22c. DATE SIGNED 11-23-68	DEGREE ATTENDING PHYS	<input checked="" type="checkbox"/> MED DIRECTOR	<input type="checkbox"/> STAFF PHYS	
22d. PHYSICIAN'S NAME (Type) FIDEL J. QUIN-TOWD	22e. ADDRESS 8715 First Ave, S. Spring, MD			
23a. BURIAL, CREMATON, REMOVAL (Specify) Burial	23b. DATE 11/25/1968	23c. NAME OF CEMETERY OR CREMATORIUM Fort Lincoln Cemetery	23d. LOCATION (City or Town) Colmar Manor	(County) Maryland (State)
24. FUNERAL DIRECTOR Lee H. Marshall 300 4th St. N.E. Washington, D.C.	ADDRESS	25a. REC'D BY REGISTRAR NOV 27 1968	25b. REGISTRAR'S SIGNATURE Charles Judge	



17

FOR STATE  
HEALTH DEPT.

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death if necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2 and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

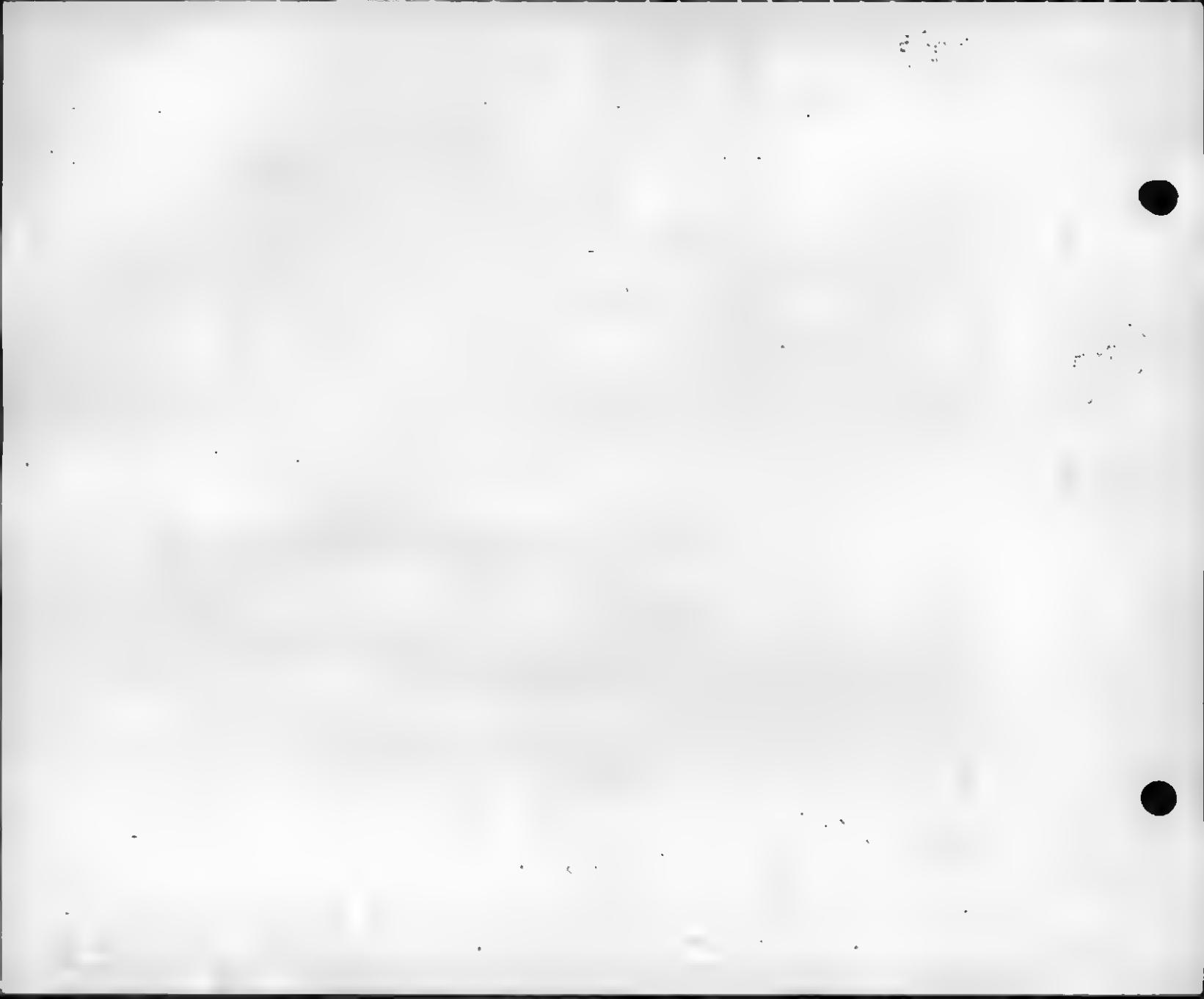
**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

16370

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

16384

1. DECEASED NAME (Type or Print)		First Glenn	Middle Edward	Last Kitchin	2a DATE KNOWN OF ESTI- DEATH MATED <input checked="" type="checkbox"/> 11-24-68	Month 11	Day 30pm	Year 1968	2b HOUR 2d HOUR		
3 SEX Male	4 RACE White	5 DATE OF BIRTH 3-23-1918	6 AGE (in years last birthday) 50 yrs	F UNDER MONTHS YEARS DAYS HOURS MIN	11c DATE PRONOUNCED DEAD Month 11 Day 24 Year 68 1968 11-24-68						
7a BIRTHPLACE (State or foreign country) Kansas		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Prince George's Md.						
10 CITY OR TOWN OF DEATH Cheverly			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospito- r give street address) Prince George Hospital			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Printer			12b KIND OF BUSINESS OR INDUSTRY U.S. Government		
13a. USUAL RESIDENCE (Where deceased lived, if institution on admission) STATE Maryland			13b. COUNTY Prince George's			13d. INSIDE CITY LIMITS YES <input type="checkbox"/> NO <input type="checkbox"/>			13e STREET AND NUMBER 6131 Montrose Avenue		
14. FATHER'S NAME First Wilbur G. Kitchin			Middle Last			15. MOTHER'S MAIDEN NAME First Cora Williams					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) yes			16b. SOCIAL SECURITY NO. WW II			17. INFORMANT Opal Kitchin			ADDRESS Cheverly, Md.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Heart failure			DUE TO, OR AS A CONSEQUENCE OF Severe coronary arteriosclerosis						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH minutes over 5 yrs.		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			(b)								
			DUE TO, OR AS A CONSEQUENCE OF								
			(c)								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
4101											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a. MEDICAL CERTIFICATION EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No			City or Town	County	State
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>										22b. DATE SIGNED 11-25-68	
ACTUAL SIGNATURE John Kehoe MD			EXAMINER'S NAME (Type) John Kehoe MD			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	ADDRESS (Street, city, town, or county) Riverdale, Md.
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE Nov 27, 1968		23c. NAME OF CEMETERY OR CREMATORIAL Ft Lincoln Cemetery			23d. LOCATION (City or Town) Colmar Manor Pro Geo			(County) Md.	(State)
24. FUNERAL DIRECTOR F. Gachs Sons		ADDRESS Hyattsville, Md.			25a. REC'D BY REGISTRAR DATE NOV 27 1968			25b. REGISTRAR'S SIGNATURE j Charles Judge			



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No.

16371

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician and completely filled in.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Prince Georges County MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville	c. LENGTH OF STAY IN lb	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 3450 Toledo Terrace		d. STREET ADDRESS 3450 Toledo Terrace	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Peter	First T.	Middle Kossiaras	Last Month 11 Day 3 Year 1968
4. DATE OF DEATH			
5. SEX male	6. COLOR OR RACE Caucasian	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-15-1895
9. AGE (In years from birthday) 73 yrs.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired	10b. KIND OF BUSINESS OR INDUSTRY -	11. BIRTHPLACE (State or foreign country) Greece
12 CITIZEN OF WHAT COUNTRY? United States			
13. FATHER'S NAME Anastasios Kossiaras	14 MOTHER'S MAIDEN NAME Voutsas		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) no	16. SOCIAL SECURITY NO 126-09-5461	17. INFORMANT Mr. Thomas Kossiaras, Son, same as item #2	Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)  Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) (c)		INTERVAL BETWEEN ONSET AND DEATH 1 hour	
(1) Cardiac arrest (2) Arterosclerotic heart disease (3) Generalized arterosclerosis		5 years 10 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I cirrhosis of the liver (alcoholic)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m p. m.	19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 1968, 19, to 11-3, 1968, that I last saw the deceased alive on 10-30, 1968, and that death occurred at 8 a.m., from the causes and on the date stated above.			
ACTUAL SIGNATURE James J. Burns	ADDRESS (Street, city or town, state) 1835 1st Ave. 11-3-68		DATE SIGNED 11-3-68
PHYSICIAN'S NAME (Type) James T. Burns	22a. BURIAL, CREMATION, REMOVAL (Specify) Burial 11-5-1968		
	22b. DATE THEREOF 11-5-1968	22c. NAME OF CEMETERY OR CREMATORIUM Fort Lincoln Cemetery	22d. LOCATION (City, town, or county) Bladensburg, Prince Georges Co. (State) Md.
23. FUNERAL DIRECTOR'S SIGNATURE Joseph Gawler's Sons, Inc., 5130 Wisc. Ave. N.W., Wash., D.C., 20016	ADDRESS 5130 Wisc. Ave. N.W., Wash., D.C., 20016	24a. REC'D BY REGISTRAR NOV 7 1968	24b. REGISTRAR'S SIGNATURE Charles Judge



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 72 hours after death if necessary, please execute the certificate, writing the word "pending" in pen in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with farm files. To FUNERAL DIRECTOR: Page 3 should be used as a burial transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

Item 18 Film 409 2-14-MARYLAND STATE DEPARTMENT OF HEALTH  
16372 DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

16336

1. DECEASED NAME (Type or Print)		DELPHIA Delphia	Middle KATHERINE	Last Kraft	2a. DATE KNOWN OF ESTI. DEATH MATED	Month 11	Day 27	Year 68	2b. HOUR 19 PM
3. SEX Female	4. RACE White	5. DATE OF BIRTH 1/27/12	6. AGE (In years last birthday) 56	7. IF UNDER 1 YEAR MONTHS YRS	8. IF UNDER 24 HRS HOURS Min	2c. DATE PRONONCED DEAD Month 1 Day 28 Year 68 2d. HOUR 3:30pm M			
7a. BIRTHPLACE (State or foreign country) Va.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED WIDOWED DIVORCED	9. COUNTY OF DEATH Prince George's	Md			
10. CITY OR TOWN OF DEATH Hyattsville		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 4513 Burlington Road			12a. USUAL OCCUPATION (Kind of work done during life or if retired.) Housewife			12b. KIND OF BUSINESS OR INDUSTRY Home	
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) Maryland		13c. CITY OR TOWN Prince George's		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 4513 Burlington Road			
14. FATHER'S NAME Dela Davis Gilmer		15. MOTHER'S MAIDEN NAME Estta Alice Bowman							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? UNKNOWN		16b. SOCIAL SECURITY NO Unknown		17. INFORMANT (Mother) Estta A. Gilmer, 715 N. Liberty St., Harrisburg, Pa.		ADDRESS			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Acute alcoholism</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause last <b>3039</b> (b) DUE TO, OR AS A CONSEQUENCE OF (c)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>3220</b>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day Year HOUR A.M. P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No		City or Town		County State	
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspect an <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE <i>John Kehoe</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22b. DATE SIGNED 11-29-68			
EXAMINER'S NAME (Type) John Kehoe MD		Riverdale, Md.		ADDRESS (Street, city, town, or county)					
23a. BURIAL CREMATORIUM REMOVAL SPECIES Organization		23b. DATE 12-8-68		23c. NAME OF CEMETERY OR CREMATORIUM Mt. Lincoln Cemetery		23d. LOCATION (City or Town) Prince George's Co., Md.		(County) (State)	
24. FUNERAL DIRECTOR Name		ADDRESS Home, Mt. Rainier, Md.		25a. RECEIVED BY REGISTRAR DATE DEC 5 1968		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			



## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item#5, FilmGL06 11/21/68 km

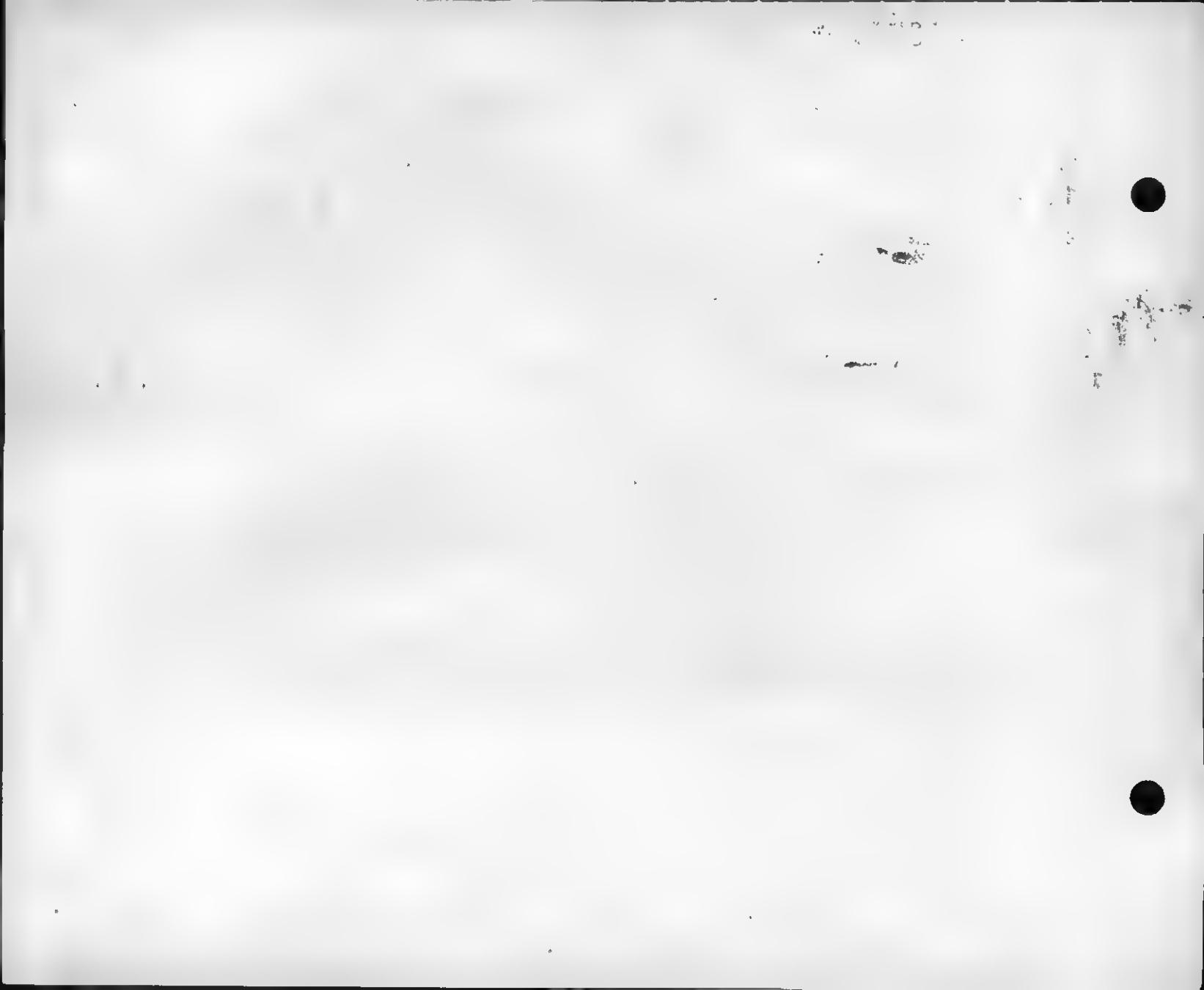
## CERTIFICATE OF DEATH

1638

**10 HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.  
**10 FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician or attending physician, page 4 may be retained by the hospital or attending physician.

**10 FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician or attending physician, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

1. DECEASED NAME (Type or print)	First <b>Annie</b>	Middle <b>May</b>	Last <b>Kronheim</b>	20. DATE OF DEATH <b>Nov. Month 9 Day 68 Year</b>	2b. HOUR <b>4:05 AM</b>	
3. SEX <b>Female</b>	4. RACE <b>White</b>	5. DATE OF BIRTH <b>1903 Oct 29, 1968</b>	6. AGE (in years from last birthday) <b>65</b>	7. IF UNDER 1 YEAR MONTHS <input checked="" type="checkbox"/>	8. IF UNDER 24 HRS. HOURS <input type="checkbox"/>	
7a. BIRTHPLACE (State or foreign country) <b>Va</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	B. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH <b>Pro George's</b>			
10. CITY OR TOWN OF DEATH <b>Forestville</b>	11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital 9. via street address) <b>Regent Nursing home</b>	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Retired Food Mgr</b>	12b. KIND OF BUSINESS OR INDUSTRY <b>Drug Store</b>			
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE <b>Md</b>	13c. CITY OR TOWN <b>Pro Geo Colmar Manor</b>	13d. INSIDE CITY LIMIT YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER <b>4105 Newton st</b>			
14. FATHER'S NAME First <b>John A Bradshaw</b>	Middle <b></b>	15. MOTHER'S MAIDEN NAME First <b>Fannie M Zimmerman</b>	Middle <b></b>	16. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <b>No</b>	16b. SOCIAL SECURITY NO <b>577 10 1407D</b>	17. INFORMANT <b>Phyllis Seiferth</b>	Address <b>Colmar Manor, Md.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)						
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Right Pulmonary Carcinoma of Lungs, Middle Lobe, with Abscess Formation</b>						
DUE TO, OR AS A CONSEQUENCE OF						
(b) <b>Right Bronchial Pneumonia</b>						
DUE TO, OR AS A CONSEQUENCE OF						
(c)						
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)						
/ / / X						
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>Yes</b>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING ETC)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State	
22a. I certify that (I) <b>OLIVER K. BOND</b> attended the deceased from <b>Sept 10, 1968</b> to <b>Nov 8, 1968</b> , that (I) <b>never</b> last saw the deceased alive on <b>Nov 8, 1968</b> , and that in (my) <b>my</b> opinion death occurred on the date and hour and from the causes stated above, (I) <b>never</b> (did) (did not) view the body after death.						
22b. SIGNATURE <b>Oliver K. Bond</b>	DEGREE <b>MD</b>	ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. D.RECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	22c. DATE SIGNED <b>11/19/68</b>	
22d. PHYSICIAN'S NAME (Type) <b>OLIVER K. BOND</b>	22e. ADDRESS <b>6872 Riverdale Rd. Lanham MD 20801</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>	23b. DATE <b>Nov 12, 1968</b>	23c. NAME OF CEMETERY OR CREMATORIAL <b>Ft Lincoln Crematory</b>	23d. LOCATION (City or Town) <b>Colmar Manor Pro Geo Md.</b>	(County)	(State)	
24. FUNERAL DIRECTOR <b>F Gasch's Sons</b>	ADDRESS <b>Hyattsville, Md.</b>	25a. RECD BY REGISTRAR DATE <b>NOV 18 1968</b>	25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			



## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16388

## CERTIFICATE OF DEATH

**10 HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.  
 Page 4 may be retained by the hospital or attending physician.

**10 FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 DECEASED NAME (Type or print)	First	Middle	Lost	2a. DATE OF DEATH Month Nov 24, 1968	2b. HOUR Doy Year 11 A M
Raymond	M.	Lambert			
3 SEX male	4. RACE white	S. DATE OF BIRTH April 3, 1920	6 AGE (in years lost birthday) 48	IF UNDER 1 YEAR MONTHS YRS.	IF UNDER 24 MRS. HOURS MIN.
7a. BIRTHPLACE (State or foreign country) West Va	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9 COUNTY OF DEATH Prince George's	Md.	
10 CITY OR TOWN OF DEATH Bowie	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 12314 Thompson Road Bowie	12a. US.JA. OCCUPATION (Kind of work done during most of workng life, even if ret red.) Retired Supt construction	12b. KIND OF BUSINESS OR INDUSTRY D.C. Govt.		
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE Md	13c. CITY OR TOWN Prince George's Bowie	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 12314 Thompson Road		
14. FATHER'S NAME First Willie L Lambert	Middle Lambert	Lost	15. MOTHER'S MAIDEN NAME First Maggie L Trainer	Middle	Lost
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) no	16b. SOCIAL SECURITY NO 232 24 4271	17 INFORMANT Sara V. Lambert	Address Bowie, Md.		
<b>18 CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c)) <b>PART I. DEATH WAS CAUSED BY:</b> <b>IMMEDIATE CAUSE (a)</b> <i>Pneumonia</i> <i>1621</i> <b>DUE TO, OR AS A CONSEQUENCE OF</b> <b>Conditions if any, which gave rise to immediate cause (a), stating the underlying cause</b> <b>(b)</b> <i>Bronchogenic Carcinoma</i> <b>DUE TO, OR AS A CONSEQUENCE OF</b> <b>(c)</b>					
<b>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</b> <i>2 days</i> <i>6 months</i>					
<b>PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)</b> <i>163</i>					
19a. DATE OF OPERATION <i>6/28/68</i>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>Bronchogenic Carcinoma</i>	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACC DENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJRY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)		
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJRY (At HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No	City or Town	County State
<b>22o. I certify that (I) (this hospital) attended the deceased from <i>May 3, 1968</i>, to <i>Nov. 24, 1968</i>, that (I) (we) lost saw the deceased alive on <i>Nov 24, 1968</i>, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.</b>					
22b. SIGNATURE <i>Leonard P. Appel MD.</i>		DEGREE ATTENDING PHYS	MED DIRECTOR	STAFF PHYS	22c. DATE SIGNED <i>Nov 24, 1968</i>
22d. PHYSICIAN'S NAME (Type) LEONARD P. APPEL, M.D.		22e. ADDRESS <i>3231 SUPERIOR LA. BOWIE, MD.</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE Nov 27, 1968	23c. NAME OF CEMETERY OR CREMATORIAL Ft Lincoln Cemetery	23d. LOCATION (City or Town) Colmar Manor Pro Geo	(County) Md.	(State)
24. FUNERAL DIRECTOR F. Gasch's Sons	ADDRESS Hyattsville, Md.	25a. REC'D BY REGISTRAR DATE NOV 27 1968	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		



MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

16375

1638

**10 HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.  
**10 FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician or director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

1. DECEASED-NAME (Type or Print)				First	Middle	Last	2a. DATE OF DEATH Month Day Year	2b. HOUR AM				
<b>FLORENCE J. LEHMAN</b>							NOV 16 1968	4:30 AM				
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (in years last birthday)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN		
<b>FEMALE</b>		<b>WHITE</b>		<b>JUNE 6 1896</b>		<b>72 yrs</b>						
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED WIDOWED <input checked="" type="checkbox"/>		NEVER MARRIED DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		12b. KIND OF BUSINESS OR INDUSTRY		
<b>PENN.</b>		<b>U.S.A.</b>						<b>PRINCE GEORGES</b>				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY			
<b>RIVERDALE</b>			<b>LEELANU MEM. HOSP.</b>			<b>HOUSEWIFE</b>						
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INS OR CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER				
<b>M.D.</b>		<b>PRINCE GEORGES</b>		<b>HYATTSVILLE</b>				<b>4018 MADISON ST.</b>				
14. FATHER'S NAME First Middle Last				15. MOTHER'S MAIDEN NAME First Middle Last								
<b>UNKNOWN</b>				<b>UNKNOWN</b>								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		(If yes give war or dates of service)		16b. SOCIAL SECURITY NO		17. INFORMANT		Address <b>6208 AGER RD</b>				
<b>No</b>				<b>579286013</b>		<b>DALTON G. LEHMAN</b>		<b>W HYATTSVILLE, MD</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Myocardial Infarction</b> , <b>Sudden</b> Due to, or as a consequence of <b>Diffuse Myocardial Ischemia</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) <b>due to advanced Coronary Sclerosis</b> , <b>5 yrs</b> Due to, or as a consequence of (c)												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)												
MEDICAL CERTIFICATION		19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State								
22a. I certify that (I) (this hospital) attended the deceased from <b>5/5</b> , 19 <b>54</b> , to <b>11/16</b> , 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>10/29</b> , 19 <b>68</b> , and that in (my) ( <u>our</u> ) opinion death occurred on the date and hour and from the causes stated above, (I) ( <u>we</u> ) (did) (did not) view the body after death.												
22b. SIGNATURE <b>Daniel D. Washington Jr.</b>		DEGREE ATTENDING PHYS		MED. DIRECTOR <input checked="" type="checkbox"/>		STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED <b>11/18/68</b>				
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS <b>5602 Ridgefield Rd BETHESDA, MD 20816</b>										
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE <b>Nov 18 1968</b>		23c. NAME OF CEMETERY OR CREMATORIAL <b>FT. LINCOLN, CEM</b>		23d. LOCATION (City or Town) <b>CORNER MANOR MD</b>		(County)		(State)		
24. FUNERAL DIRECTOR <b>1400 Chambers Rd</b>		ADDRESS <b>WASH D.C.</b>		25a. RECD BY REGISTRAR <b>NOV 26 1968</b>		25b. REGISTRAR'S SIGNATURE <b>James</b>						



MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
CERTIFICATE OF DEATH

16378

**10 HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.  
 Page 4 may be retained by the hospital or attending physician.  
**10 FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician, the director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 DECEASED NAME (Type or print)		First  Helen	Middle  R.	Lost  Lewis	2a. DATE OF DEATH Month 11-22-68	Day	Year	2b. HOUR 7:20 AM
3. SEX		4. RACE		S. DATE OF BIRTH  12-24-92	6. AGE (In years last birthday)  75 yrs.		F. UNDER 1 YEAR MONTHS	IF UNDER 24 HRS. HOURS
Female		White		7b. CITIZEN OF WHAT COUNTRY?  USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH  Prince George	
10 CITY OR TOWN OF DEATH  Riverdale		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)  Eugene Leland Memorial		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)  maid		12b. KIND OF BUSINESS OR INDUSTRY  Restaurant		
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE  Maryland		13b. CITY OR TOWN  Prince George		13c. INSIDE CITY LIMITS?  YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER  5700 Baltimore Ave.,		
14 FATHER'S NAME First  Charles Harry		Middle  Lewis	Last	15. MOTHER'S MAIDEN NAME First  Edith W.				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown  no		16b. SOCIAL SECURITY NO.  216 22 1091A		17. INFORMANT  Miss Margaret Rose / friend / Medical Records		Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)  CEREBROVASCULAR INSUFFICIENCY DUE TO, OR AS A CONSEQUENCE OF GEN. ARTERIOSCLEROSIS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  ONE YEAR
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)  ACUTE VIRÉMIA								UNKNOWN
19a. MEDICAL CERTIFICATION DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING ETC)		21f. LOCATION Street or R.F.D. No City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from 11 - 3, 1968, to 11 - 22, 1968, that (I) (we) last saw the deceased alive on 11-21-68, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.								
22b. SIGNATURE  (C) Houmann		DEGREE ATTENDING PHYS	<input checked="" type="checkbox"/>	MED DIRECTOR	<input type="checkbox"/>	STAFF PHYS	<input type="checkbox"/>	22c. DATE SIGNED  22 Nov 68
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS  C. J. Houmann, M.D.						
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE  Nov 26, 1968		23c. NAME OF CEMETERY OR CREMATORIUM  Glenwood Cemetery		23d. LOCATION (City or Town) (County) (State) Washington D. C.		
24. FUNERAL DIRECTOR  F. Gasch's Sons		ADDRESS  Hyattsville, Md.		25a. REC'D BY REGISTRAR  Charles Judge		25b. REGISTRAR'S SIGNATURE  DATE NOV 27 1968		



**10 HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

**10 FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

16377

**MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201**

**CERTIFICATE OF DEATH**

1639

1 DECEASED NAME (Type or print)		First <b>MILDRED</b>	Middle <b>AGNES</b>	Last <b>LEWIS</b>	2a. DATE OF DEATH Month <b>NOVEMBER</b>	Day <b>3</b>	Year <b>1968</b>	2b. HOUR A <b>6:15 M</b>
3. SEX <b>FEMALE</b>	4. RACE <b>CAU</b>	5. DATE OF BIRTH <b>23 JAN 1902</b>			6. AGE (In years last birthday) <b>66</b>	7. IF UNDER 1 YEAR MONTHS <b>YRS.</b>	8. IF UNDER 24 HRS. HOURS MIN	
7a. BIRTHPLACE (State or foreign country) <b>VIRGINIA</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input checked="" type="checkbox"/>	DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH <b>PRINCE GEORGE'S</b>			
10. CITY OR TOWN OF DEATH <b>ANDREWS AFB</b>	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>MALCOLM GROW USAF HOSP</b>	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>HOUSEWIFE</b>			12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) <b>VIRGINIA</b>	13c. CITY OR TOWN <b>LNORTHUMBLAND</b>	13d. INSIDE CITY (L.M.T.P.) <input checked="" type="checkbox"/>	13e. STREET AND NUMBER <b>BOX 95</b>					
14. FATHER'S NAME <b>ZACHARIAH</b>	15. MOTHER'S MAIDEN NAME <b>HUGHES</b>	16. INFORMANT <b>DAUGHTER</b>			17. ADDRESS <b>5203 JANICE, TEMPLE HILL, MD.</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, <input checked="" type="checkbox"/> No <input type="checkbox"/> unknown	16b. SOC AL SECUR TY NO. <b>228-32-7443</b>	18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>congestive heart failure</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. <i>1538</i> (b) <i>gram negative pneumonia</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>metastatic carcinoma of colon</i>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. <input type="checkbox"/> P.M. Month Day Year <b>19</b>	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <b>22 AUG 68</b> , to <b>3 NOV 68</b> , that (I) (we) last saw the deceased alive on <b>3 NOV 1968 19</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death								
22b. SIGNATURE <i>John J. Simonaitis</i>		DEGREE ATTENDING PHYS	<input type="checkbox"/> MED. DIRECTOR	<input type="checkbox"/> STAFF PHYS	22c. DATE SIGNED <b>3 NOV 1968</b>			
22d. PHYSICIAN'S NAME (Type) <b>JOHN J. SIMONAITIS, CAPT, USAF, MC</b>		22e. ADDRESS <b>MALCOLM GROW USAF HOSPITAL ANDREWS AFB, WASH. D.C. 20331</b>						
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>Nov. 5-68</b>	23c. NAME OF CEMETERY OR CREMATORIAL <b>Bethany Bapt. Cemetery</b>	23d. LOCATION (City or Town) <b>Callao, Virginia</b>	(County) (State)			
24. FUNERAL DIRECTOR <i>Simmons Bros.</i>		ADDRESS <b>Wash, DC Simmons Bros. 1661-Good Hope Rd SE</b>		25a. REC'D BY REGISTRAR <b>NOV 6 1968</b>	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			



MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16378

1639

CERTIFICATE OF DEATH

**10 HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.  
**Page 4** may be retained by the hospital or attending physician.  
**10 FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician or director, page 3 should be detached for use as the burial transit permit. Then please remove carbon paper pages 1 and 2 and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print)		First	Middle	Lost	2a. DATE OF DEATH Month Day Year	2b. HOUR M
2. SEX		4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday) 59 yrs.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (State or foreign country) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Prince George	10. CITY OR TOWN OF DEATH Cheverly	
10. CITY OR TOWN OF DEATH Cheverly		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Prince George		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Dancer & singer	12b. KIND OF BUSINESS OR INDSTRY 12c. STREET AND NUMBER 103 Maryland	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Prince George	13c. CITY OR TOWN Parson	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 103 Maryland	
14. FATHER'S NAME, First		Middle	Lost	15. MOTHER'S MAIDEN NAME, First	Middle	Lost
SYDNEY H. LOWERY				LOUISE DAVIS		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown? Yes		16b. SOCIAL SECURITY NO 578-24-4808		17. INFORMANT EDITH C. LOWERY	Address Jameson 130 Bayfield	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Apparent Myocardial Infarction</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <u>coronary artery disease</u> , DUE TO, OR AS A CONSEQUENCE OF (c) <u>severe, refractory congestive failure</u>						
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <u>Pulmonary effusion, Chronic, bilateral</u>						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)		
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No	City or Town	County State
22a. I certify that (1) (this hospital) attended the deceased from <u>3 Sept., 1968</u> , to <u>11/23/1968</u> , that (2) (we) last saw the deceased alive on <u>11/16/1968</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death.						
22b. SIGNATURE <u>J. F. Lowe, MD</u>		DEGREE ATTENDING PHYS	<input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS	22c. DATE SIGNED <u>11/23/1968</u>		
22d. PHYSICIAN'S NAME (Type) J. F. Lowe		22e. ADDRESS 6056 Central Ave Capital Heights, Md.				
23a. BURIAL CREMATION, REMOVAL (Specify) Burial		23b. DATE 11-25-1968	23c. NAME OF CEMETERY OR CREMATORIUM Christ Church	23d. LOCATION (City or Town) Chaptico	(County) St. Marys	(State) Md.
24. FUNERAL DIRECTOR, Mortuary		ADDRESS 131-11th St. S.E. D.C.		25a. REC'D BY REG. STRR DATE NOV 27 1968	25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

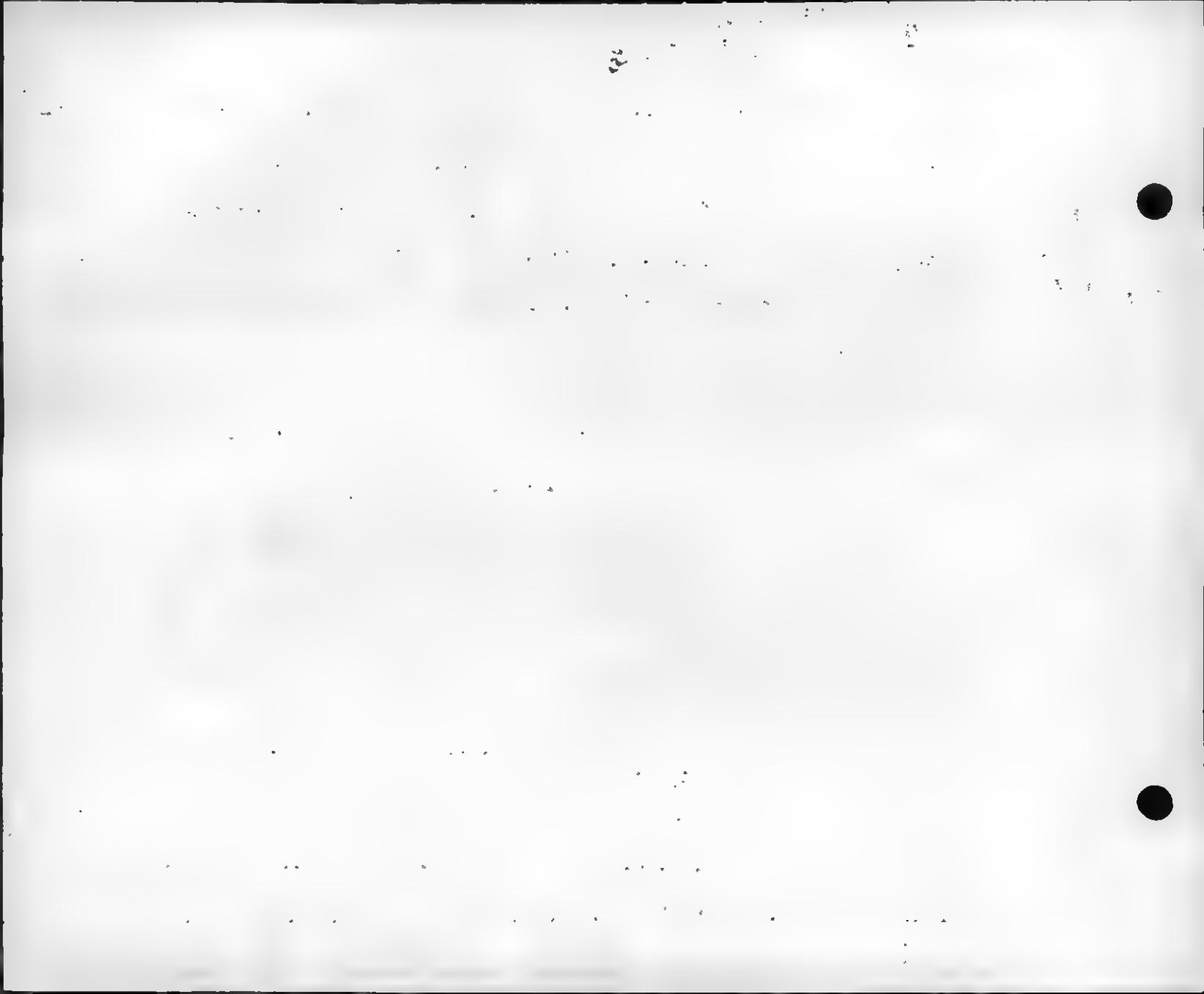
16379

16379

**10 HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completed, file it in the funeral director's office. If you do not have a funeral director, page 3 should be detached for use as a burial-transit permit. Then please remove carbon paper, pages 1 and 2, within 72 hours after death. This certificate should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

1. DECEASED NAME (Type or print)		First <b>Nicholas</b>	Middle <b>J.</b>	Last <b>Lutzio</b>	2a. DATE OF DEATH Month <b>Nov.</b> Day <b>18,</b> Year <b>1968</b>	2b. HOUR <b>6:15 P.M.</b>	
3. SEX <b>Male</b>	4 RACE <b>Caucasian</b>	5. DATE OF BIRTH <b>Oct. 27, 1907</b>			6. AGE (In years last birthday) <b>61</b> YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS HOURS MIN
7a. BIRTHPLACE (State or foreign country) <b>Pa</b>	7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	B MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> SEP. <input type="checkbox"/> DIVORCED	9. COUNTY OF DEATH <b>Prince George's</b>			Md	
10. CITY OR TOWN OF DEATH <b>Cheverly</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Prince Geo. Gen'l Hospital</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even part-time) <b>Insurance agent</b>	12b. KIND OF BUSINESS OR INDUSTRY <b>Insurance</b>	
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <b>Maryland</b>		13b. CITY OR TOWN <b>Prince George's</b>	13d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input type="checkbox"/> NO	13e. STREET AND NUMBER <b>8604 Fremont Street</b>			
14. FATHER'S NAME First <b>Joseph Lutzio</b>	Middle	Last	15. MOTHER'S MAIDEN NAME First Middle <b>Maria</b>	Last <b>Pipino</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown)	16b. SOCIAL SECURITY NO. (If yes give war or dates of service)	17. INFORMANT			Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) <b>Part I. Death was caused by:</b> <b>IMMEDIATE CAUSE (a)</b> <i>generalized carcinomatosis</i> <b>151</b> <b>due to, or as a consequence of</b> <b>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause</b> <i>cancer of stomach</i> <b>(b)</b> <b>due to, or as a consequence of</b> <b>(c)</b>							
<b>Part 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)</b> <b>151 X</b>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No	City or Town	County	State	
22a. I certify that (I) <input checked="" type="checkbox"/> attended the deceased from <b>Nov. 7, 1968</b> , to <b>Nov. 18, 1968</b> , that (I) <input checked="" type="checkbox"/> last saw the deceased alive on <b>Nov. 18, 1968</b> , and that in (my) <input checked="" type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above, (I) <input checked="" type="checkbox"/> did <input type="checkbox"/> not view the body after death.							
22b. SIGNATURE <i>A.S. Banisar M.D.</i>		22c. DEGREE <input checked="" type="checkbox"/> ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS.	DATE SIGNED <b>11-19-18</b>				
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS <b>6323 Landover Rd., Cheverly, Maryland</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE <b>Nov. 21, 1968</b>	23c. NAME OF CEMETERY OR CREMATORIAL <b>St. Cecilia's Cem</b>		23d. LOCATION (City or Town) <b>Coatesville, Pa</b>	(County)	(State)
24. FUNERAL DIRECTOR <i>Worobay J.H.</i>		ADDRESS <i>Hawthorne Md</i>		25a. REG'D BY REGISTRAR DATE <b>NOV 25 1968</b>	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		



FOR STATE  
HEALTH DEPT.



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 8. Give Pages \_\_\_\_\_ to the funeral director. Page 1 should be forwarded to the Chief Medical Examiner's Office along with farm 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used for a burial-transit permit or removal, and in any event within 72 hours after death. Health prior to burial, creation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

16380

1 DECEASED NAME (Type or Print)				First	Middle	Last	2a DATE KNOWN OF ESTI- DEATH MADE	Month	Day	Year	2b HOUR		
				James	Joseph	Malone	<input checked="" type="checkbox"/>	11-7-68	19	8:30am			
3 SEX	4 RACE	S. DATE OF BIRTH	6 AGE (in years lost birthday)	IF UNDER 1 YEAR		IF UNDER 24 HRS							
Male	White	4-27-1924	44 yrs	MONTHS	DAYS	HOURS	MIN						
7a BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED		NEVER MARRIED		9 COUNTY OF DEATH					
New York		U S A		<input checked="" type="checkbox"/>		<input type="checkbox"/>		Prince George's					
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address)		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b KIND OF BUSINESS OR INDUSTRY							
Cheverly		Prince George Hospital		Mail Handler		U S Government							
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)		13b. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER							
Maryland		Prince George's		Hyattsville		YES <input type="checkbox"/>	NO <input type="checkbox"/>	7630 Greeley Road					
14. FATHER'S NAME				First	Middle	Last	15. MOTHER'S MAIDEN NAME				First	Middle	Last
				Daniel Malone				Mae Shumaker					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16b. SOCIAL SECURITY NO. <small>(If yes, give name or dates of service)</small>		17. INFORMANT				ADDRESS			
yes				W W II		Florence Malone				Hyattsville, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Thrombotic occlusion of coronary artery													
due to, or as a consequence of Arteriosclerotic heart disease												unknown	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.				(b)				(c)					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)													
4201				19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?	
												YES <input checked="" type="checkbox"/>	NO <input type="checkbox"/>
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M.		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No.				City or Town	County	State	
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>												22b. DATE SIGNED	
ACTUAL SIGNATURE				John Kehoe				MD				CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type)				John Kehoe MD Riverdale, Md.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					
23a. BURIAL, CREMATION, REMOVAL (Specify)				23b. DATE		23c. NAME OF CEMETERY OR Crematory		23d. LOCATION (City or Town)		(County)	(State)		
Burial				Nov 11, 1968		Baltimore National		Baltimore, Md.					
24. FUNERAL DIRECTOR				ADDRESS				25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
				F. Gasch's Sons Hyattsville, Md.				DATE NOV 12 1968		Charles Judge			



FOR STATE  
HEALTH DEPT.

24 hours after death. Any delay is  
necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2 and 3 to  
the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page  
5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial transit permit. File pages 1 and 2 with the State Department of  
Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 DECEASED NAME (Type or Print)		First	Middle	Lost	2a DATE KNOWN OF DEATH MATED	Month	Day	Year	2b HOUR
		Beatrice	Mary	Mamo	<input checked="" type="checkbox"/>	11	13	68	19 2:00am M
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (in years lost birthday)	F UNDER 1 YEAR MONTHS      DAYS	IF UNDER 24 HRS HOURS      MIN	2c DATE PRONOUNCED DEAD Month Day Year			
Female	White	11-29-1925	42 YRS			2d HOUR			
7a BIRTHPLACE (State or foreign country)	7b CITIZEN OF WHAT COUNTRY?	8	MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9 COUNTY OF DEATH				Prince George's	
Pa	U S A								
10 CITY OR TOWN OF DEATH	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a USUAL OCCUPATION (Kind of work done during most of working life even if retired.)				12b KIND OF BUSINESS OR INDUSTRY
Cheverly	Prince George's Hospital				Housewife				Home
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER					
Maryland	Prince George's	Bowie	YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	12207 Maller Lane					
14. FATHER'S NAME	First	Middle	Lost	15. MOTHER'S MAIDEN NAME	First	Middle	Lost	Katherine Fitzgerald	
Frank Hills									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	16b. SOCIAL SECURITY NO	17. INFORMANT	ADDRESS						
no		Bartholomew G Mamo	Bowie, Md.						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY									
IMMEDIATE CAUSE (a) Hemorrhagic shock									
DUE TO, OR AS A CONSEQUENCE OF Rupture of oesophageal varix									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) last									
DUE TO, OR AS A CONSEQUENCE OF									
(c)									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
4.1		19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?	
								YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
MEDICAL CERTIFICATION		21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day Year HOUR A.M.      P.M.      19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
		21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No.      City or Town      County      State			
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE		<i>John Kehoe</i>							CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D.
EXAMINER'S NAME (Type)		John Kehoe MD Riverdale, Md.							ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIUM		23d. LOCATION (City or Town)		(County) (State)	
Burial		Nov 16, 1968		Mt Olivet Cemetery		Washington D. C.			
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
F. Gasch's Sons		Hyattsville, Md.				NOV 18 1968		<i>Charles J. Gasch</i>	

1980

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in part in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form P.M.C. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Health Dept. prior to burial, cremation, or removal, and in any event within 72 hours after death.

16382 MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Items #7a, b, & 8, Film MEDICAL EXAMINER'S CERTIFICATE OF DEATH

16396

1 DECEASED NAME (Type or Print)		First	Middle	Last	2a. DATE KNOWN OF ESTI- DEATH MATED	Month	Day	Year	2b. HOUR		
Roy C Mangum Jr					<input checked="" type="checkbox"/>	11	9	1968	12:50 am		
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (in years last birthday)	7 IF UNDER 1 YEAR MONTHS DAYS	8. MARRIED W DIVORCED	9 COUNTY OF DEATH					
Male	Negro	8-2-1932	36 yrs.		NEVER MARRIED DIVORCED	Prince George's					
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8. MARRIED W DIVORCED		10 CITY OR TOWN OF DEATH					
North Carolina		USA				Cheverly					
11 NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address)		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b KIND OF BUSINESS OR INDUSTRY		13a USUA. RESIDENCE (Where deceased lived, if institution Residence before					
Prince George Hospital						13c. CITY OR TOWN				13d. INSIDE CITY, MTS?	13e STREET AND NUMBER
13f. STATE		13g. COUNTY		13h. ADDRESS		Maryland				YES <input type="checkbox"/> NO <input type="checkbox"/>	Rt. 1, Box 1020
14 FATHER'S NAME		First	Middle	Last	15. MOTHER'S MAIDEN NAME	First	Middle	Last			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO.		17 INFORMANT		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
(If yes give war or dates of service)						PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 3rd. degree burns of 100% body surface					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last		(b)		DUE TO, OR AS A CONSEQUENCE OF							
		(c)		DUE TO, OR AS A CONSEQUENCE OF							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
9/17											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		19c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b.)		20 AUTOPSY?					
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M.		21c. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21d. LOCATION Street or R.F.D. No		City or Town	County	State	
21e. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>		12:45 pm 11-9- 1968		home		same as #13.					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE		<i>John Kehoe</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22b. DATE SIGNED			
EXAMINER'S NAME (Type)		John Kehoe MD Riverdale, Md.		ADDRESS (Street, city, town, or county)		11-10-68					
23a. BURIAL CREMATION REMOVAL (Specify)		23b. DATE Nov 21, 1968		23c. NAME OF CEMETERY OR CREMATORIAL Service		23d. LOCATION (City or Town) Lanier		(County) <i>Md</i>	(State)		
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
Johnson & Jenkins F.H. Inc		Wash. DC		NOV 26 1968		<i>Charles Judge</i>					
VR A15ME (5) TOM REV 1/68											



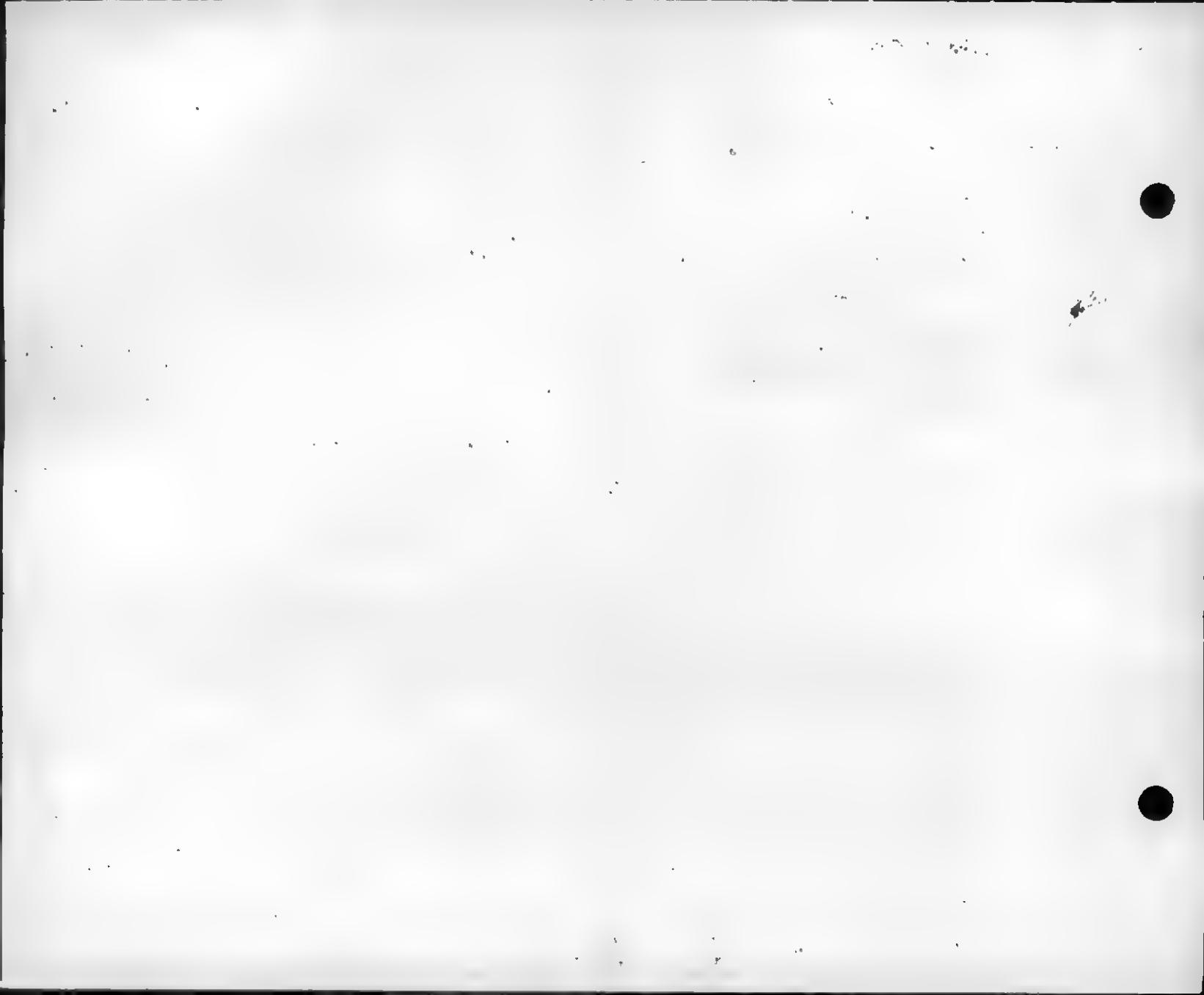
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

**10 HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

**10 FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in at the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Please and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in one event, within 72 hours after death.

1	16383				16383		
1. DECEASED NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH Month Day Year	2b. HOUR AM PM	
3. SEX		4. RACE	5. DATE OF BIRTH		6. AGE (in years last birthday) 2 yrs.	7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED WIDOWED	NEVER MARRIED DIVORCED	9. COUNTY OF DEATH	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if instit. on Reside before admission) STATE		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES NO		13e. STREET AND NUMBER	
13e. COUNT		Charles Waldorf				Rt. 3, Box 505	
14. FATHER'S NAME		First	Middle	Lost	15. MOTHER'S MAIDEN NAME	First	Middle
Wilfred					Constance		Brown
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b. SOCIAL SECURITY NO.		16c. INFORMANT		Address	
				Constance Mank		Rt. 3 Box 505 Waldorf MD	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>RESPIRATORY ARREST</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>HYDROCEPHALUS</u> DUE TO, OR AS A CONSEQUENCE OF (c)							
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>344x</u>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION	Street or R.F.D. No.	City or Town	County State
22a. I certify that (I) (this hospital) attended the deceased from <u>11/20</u> , 19 <u>68</u> , to <u>11/20</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>11/20</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did not view the body after death.							
22b. SIGNATURE <u>Philip C. Bartlett MD</u>		22c. DEGREE DEGREE		ATTENDING PHYS.	<input checked="" type="checkbox"/> MED DIRECTOR	<input type="checkbox"/> STAFF PHYS.	<input type="checkbox"/> DATE SIGNED <u>11/20/68</u>
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS <u>Brandywine Clinic</u>		22f. DATE SIGNED <u>11/20/68</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <u>Nov. 24, 1968</u>		23c. NAME OF CEMETERY OR CREMATORIAL human		23d. LOCATION (City or Town) <u>Waldoboro, Lincoln, Maine</u>	(County) (State)
24. FUNERAL DIRECTOR		ADDRESS <u>Hunt Funeral Home, Waldorf, Md.</u>		25a. REC'D BY REGISTRAR	25b. REGISTRAR'S SIGNATURE <u>Philip C. Bartlett</u>		
				DATE NO: 22 1968			



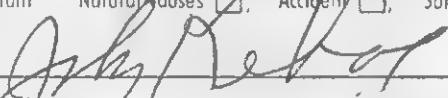
FOR STATE  
HEALTH DEPT

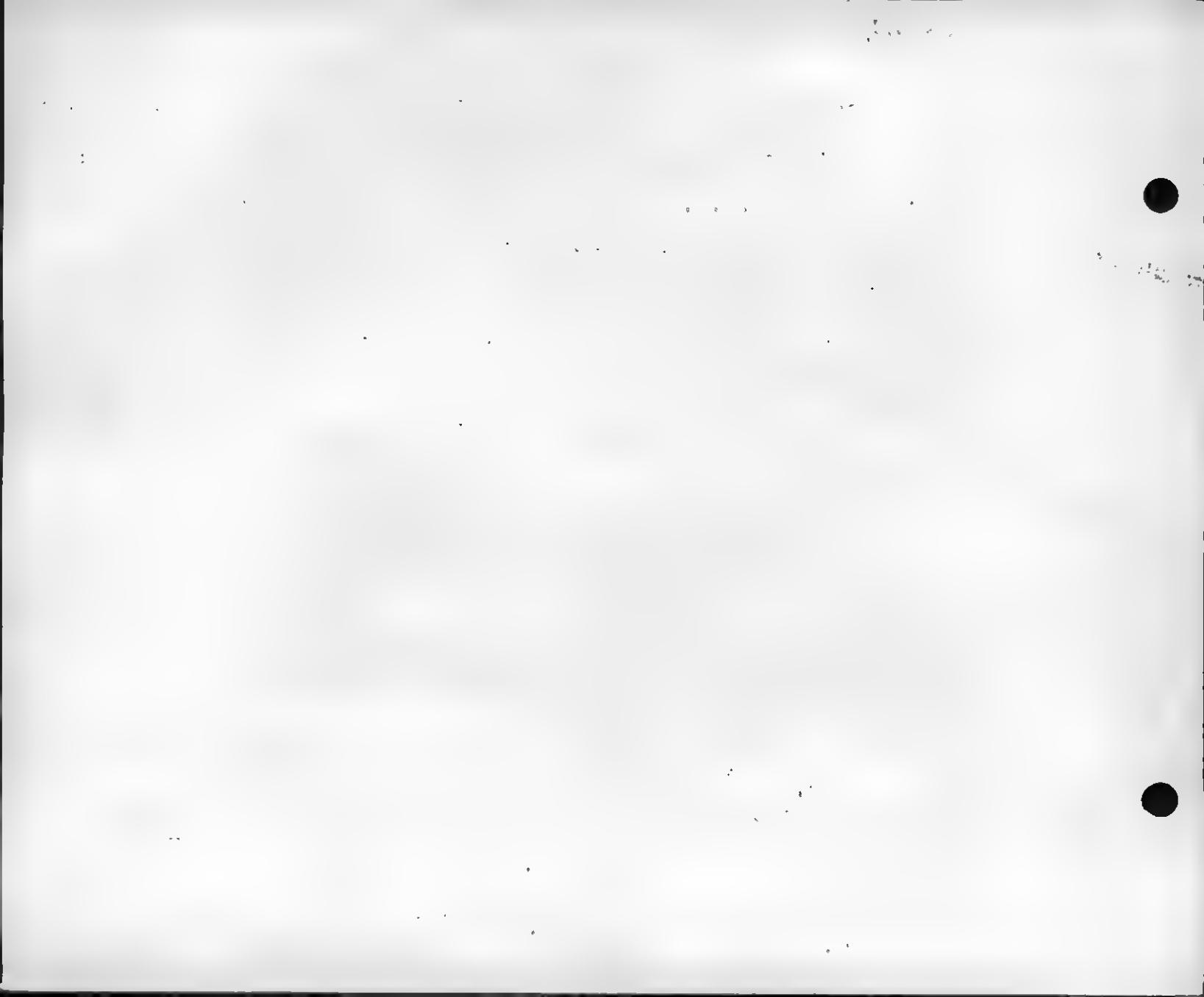
**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death if any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. File pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

Items 18&22a Film 409 MARYLAND STATE DEPARTMENT OF HEALTH  
16384 DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1638

1. DECEASED NAME (Type or Print)			First	Middle	Last	2a DATE KNOWN OF ESTI. DEATH MATED	Month	Day	Year	2b HOUR	
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (In years last birthday)	7 IF UNDER 1 YEAR MONTHS	8 IF UNDER 24 HRS HOURS	9 DATE PRONOUNCED DEAD Month	10 Month	11 Day	12 Year	13a HOURS	
Female	White	3-19-1929	39 YRS			11-22-68	19	6	00am	14a	
7b BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH		10 M.D.			
Florida		U.S.A.				Prince George Co.					
10. CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b KIND OF BUSINESS OR INDSTRY		
Cheverly			Prince George Hospital			Housewife					
13a U.S.A. RESIDENCE (Where deceased lived if institution Res dence before admission) STATE Maryland			13c CITY OR TOWN Prince George's Cheverly			13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			13e STREET AND NUMBER 6531 Landover Road		
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last								
James L. Cook			Natalie Marcisonny								
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b SOCIAL SECURITY NO			17 INFORMANT			ADDRESS		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute barbiturate intoxication DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause (b) DUE TO, OR AS A CONSEQUENCE OF (c)											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 4702											
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED?						20 AUTOPSY?		
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b TIME OF INJURY Month Day, Year HOUR A.M. P.M. 19			21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f LOCATION Street or R.F.D. No City or Town County State					
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE  EXAMINER'S NAME (Type) John Kehoe MD Riverdale, Md.											22b. DATE SIGNED 11-22-68
23a BURIAL CREMATION REMOVAL (Specify) Burial			23b DATE 11/26/68			23c NAME OF CEMETERY OR CREMATORIAL Crosby Lake Com.			23d LOCATION (City or Town) (County) (State) Starke, Florida		
24. FUNERAL DIRECTOR Valley's Funeral Home Inc.			ADDRESS 11b. Rainier Maryland			25a REC'D BY REGISTRAR DATE NOV 25 1968			25b REGISTRAR'S SIGNATURE 		



## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## CERTIFICATE OF DEATH

1639

**10 HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

**11 FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers and 2 pages and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 DECEASED NAME (Type or print)	First <b>JOHN</b>	Middle <b>E. McCall</b>	Last <b>Wells</b>	2a. DATE OF DEATH NOV Month 13 Day 68 Year 68	2b. HOUR 6:48 AM
3. SEX <b>Male</b>	4. RACE <b>White</b>	S. DATE OF BIRTH <b>May 27-1910</b>	6. AGE (in years last birthday) <b>58 yrs</b>	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (State or foreign country) <b>KANSAS</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH <b>Prince George</b> Md.		
10 CITY OR TOWN OF DEATH <b>CLINTON</b>	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Southern Md. Gen. Hosp</b>	12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>4. S. GOVT</b>	12b KIND OF BUSINESS OR INDUSTRY <b>7325-Ballard Dr. SE</b>		
13a USUAL RESIDENCE (Where deceased lived, if institution admission) STATE <b>Md</b>	13b. CITY OR TOWN <b>Pr. Geo., Clinton</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER <b>7325-Ballard Dr. SE</b>		
14. FATHER'S NAME First <b>John</b>	Middle <b>V.</b>	Last <b>McCall</b>	15 MOTHER'S MAIDEN NAME First Middle Last		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <b>No</b>	16b. SOCIAL SECURITY NO (If yes give war or dates of service)	17 INFORMANT <b>Eugenia McCall - 7325-Ballard Dr. SE</b>	Address <b>Clinton Md</b>		
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>ACUTE PULMONARY EMBOLUS</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause <b>4124</b> (b) <b>ARTERIOSCLEROTIC CARDIOVASCULAR</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>DISEASE WITH RECENT</b> <b>AVRICOAR FIBRILLATION</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>25 MIN.</b>					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>NONE</b>					
19a. DATE OF OPERATION <b>None</b>	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>None</b>	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>None</b>		
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, name medical condition) <b>None</b>	21b. TIME OF INJURY HOUR A.M. Month Day Year <b>None</b>	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) <b>None</b>			
21d. INJURY OCCURRED While at home at work	21e. PLACE OF INJURY AT HOME, FARM, STREET, FACTORY OFFICE BUILDING, ETC. <b>None</b>	21f. LOCATION Street or R.F.D. No. <b>None</b>	CITY or Town <b>None</b>	County <b>None</b>	State <b>None</b>
22a. I certify that (1) (this hospital) attended the deceased from saw the deceased alive on <b>NOV 13 1968</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (do not) view the body after death.	<b>SEPT 19 58, to PRESENT</b>				
22b. SIGNATURE <b>Arthur Shaver Jr. MD</b>	22c. ATTENDING PHYS. <b>Arthur Shaver Jr. MD</b>	22d. MED. DIRECTOR <input checked="" type="checkbox"/>	STAFF PHYS <input type="checkbox"/>	22e. ADDRESS <b>8808 Branch Ave.</b>	DATE SIGNED <b>11/13/68</b>
23a. BURIAL, CREMATION, REMOVAL (specify) <b>Burial</b>	23b. DATE <b>Nov. 16-68</b>	23c. NAME OF CEMETERY OR CREMATORIAL <b>Resurrection Cem.</b>	23d. LOCATION (City or Town) <b>Clinton, Md.</b>	(County) <b>Clinton, Md.</b>	(State) <b>Md.</b>
24. FUNERAL DIRECTOR <b>Simmons Bros</b>	ADDRESS <b>Wash DC</b>	25a. REC'D. BY REGISTRAR DATE <b>NOV 15 1968</b>	25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		



10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the full signature of the funeral director, page 3, should be detached for use as the burial-transit permit. Then please remove carbon paper, pages 1 and 2, and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

16386

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
CERTIFICATE OF DEATH

10-11-68

1. DECEASED NAME (Type or print)	First  William J. McCloskey	Middle	Last	2a. DATE OF DEATH Month November Day 16, 1968	2b. HOUR 12:30 P.M.
3. SEX Male	4. RACE White	5. DATE OF BIRTH 9/12/27	6. AGE (In years last birthday) 41	7. IF UNDER 1 YEAR YRS	8. IF UNDER 24 HRS MONTHS DAYS HOURS MIN
7a. BIRTHPLACE (State or foreign country) Penns.	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Prince George's	Md.	
10. CITY OR TOWN OF DEATH Cheverly	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Prince Geo. Gen. Hospital	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Framer	12b. KIND OF BUSINESS OR INDUSTRY -		
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE Maryland	13c. CITY OR TOWN Prince George's Mt. Rainier	13d. INSIDE CITY LIMIT? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 4309 29th St.		
14. FATHER'S NAME First Edward J. McCloskey	Middle	Last	15. MOTHER'S MAIDEN NAME First Middle Marie F. Crumback		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown Yes	16b. SOCIAL SECURITY NO. WVII	17. INFORMANT 216-22-0984	Address (above address)		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Broncho Pneumonia</u> 6 hours DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <u>Recovering from major surgery</u> DUE TO, OR AS A CONSEQUENCE OF (c)					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)					
19a. MEDICAL CERTIFICATION DATE OF OPERATION Nov 10 68	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Ruptured appendix	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY OFFICE BUILDING, ETC)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State
22a. I certify that (I) (this hospital) attended the deceased from <u>Nov 8</u> , 1968, to <u>Nov 16</u> , 1968, that (I) <input checked="" type="checkbox"/> last saw the deceased alive on <u>Nov 15</u> , 1968, and that in (my) <input checked="" type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above, (I) <input checked="" type="checkbox"/> (did) (did not) view the body after death.					
22b. SIGNATURE Dayton D. Watkins	DEGREE ATTENDING PHYS <input checked="" type="checkbox"/>	MED DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	22c. DATE SIGNED Nov 16 68	
22d. PHYSICIAN'S NAME (Type) DAYTON D. WATKINS	22e. ADDRESS 5318 Annapolis Rd Edgewater Md.				
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE 11/19/68	23c. NAME OF CEMETERY OR CREMATORIAL Ft. Lincoln Cem.	23d. LOCATION (City or Town) Colmar Manor, Md.	(County)	(State)
24. FUNERAL DIRECTOR Nalley's Funeral Home Inc.	ADDRESS Maryland	25a. RECD BY REGISTRAR	25b. REGISTRAR'S SIGNATURE Charles Judge		
VR A15 30M REV 1-68	DATE NOV 25 1968				



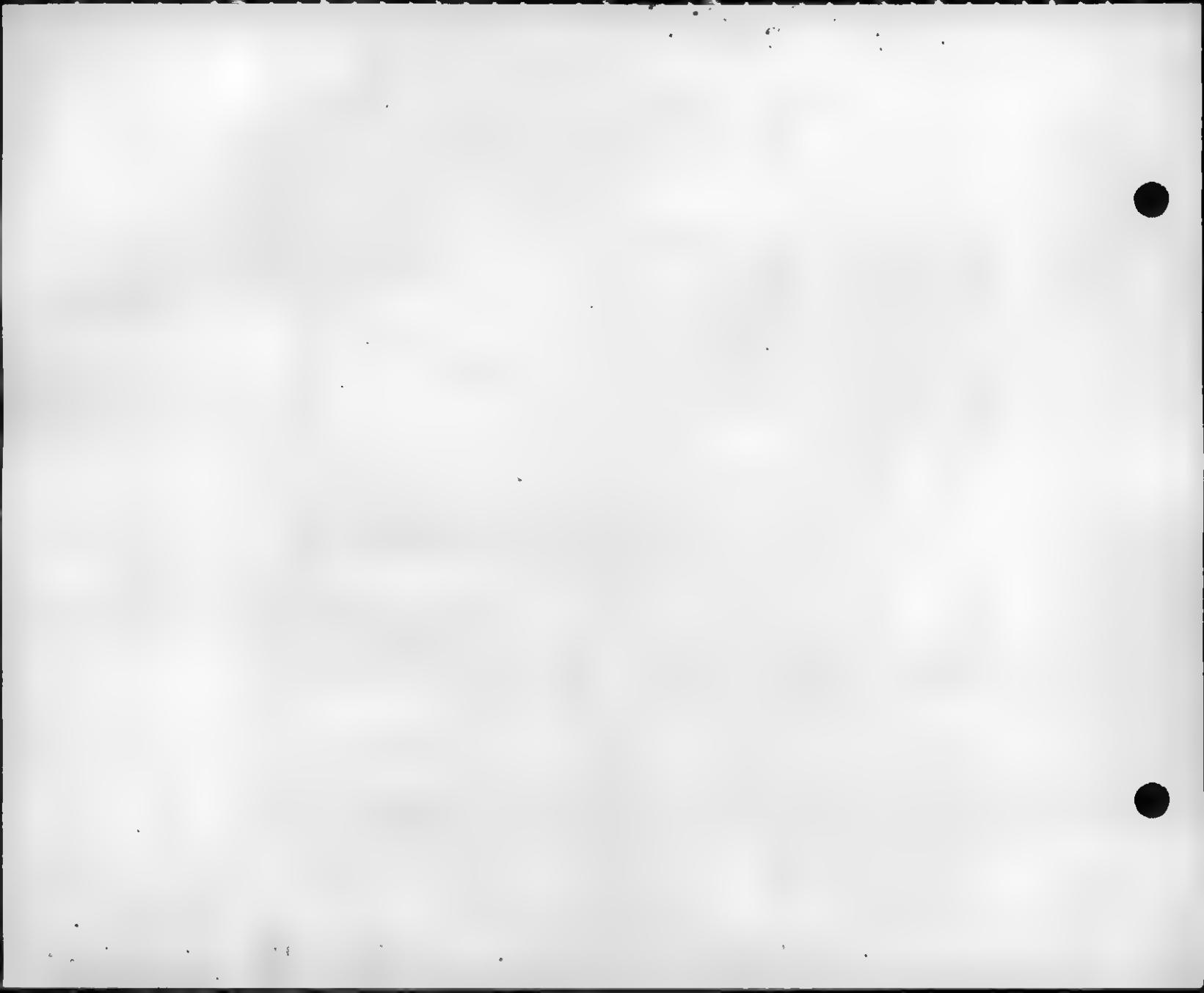
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
CERTIFICATE OF DEATH

10401

**10 HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.  
**Page 4** may be retained by the hospital or attending physician.

**10 FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. This page should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print)			First	Middle	Last	2a DATE OF DEATH Month Day Year	2b HOUR 4:55 P.M.
3. SEX male			4 RACE White	S DATE OF BIRTH 9/11/12	6. AGE (in years last birthday) 56 yrs	11 UNDER 1 YEAR MONTHS DAYS	12 UNDER 24 HRS HOURS MIN
7a BIRTHPLACE (State or foreign country) Tennessee		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH P.G.		
10 CITY OR TOWN OF DEATH Cheverly			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Prince Georges Hosp., Cheverly			12a USJAL OCCUPATION (Kind of work done during most of working life, even if retired) Logistics	
13a USUAL RESIDENCE (Where deceased lived, if institutional admission) STATE Md.			13c CITY OR TOWN Prince George Riverdale			13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e STREET AND NUMBER 55813 Quintana St.
14 FATHER'S NAME CHARLES WESEY MC GUIRE			15 MOTHER'S, MAIDEN NAME Elizabeth			12b KIND OF BUSINESS OR INDUSTRY U.S. Govt	
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No			16b. SOCIAL SECURITY NO. 578-26-3653			17 INFORMANT Fayel H. McGuire, Riverdale, Md Address	
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b) and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>① Cardiac standstill and cardiogenic shock</b> <b>4275</b> (Cardians, if any, which gave rise to immediate cause (a), stating the underlying cause) (b) <b>Severe electrolyte imbalance</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Nutrition and dehydration</b>							
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
<b>PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)</b> <b>221 Impending Delirium Tremens</b>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item .B)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, EARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f LOCATION Street or R.F.O. No	City or Town	County	State
22a. I certify that (I) (this hospital) attended the deceased from <b>10-31-1968</b> to <b>11-4-1968</b> , that (I) (we) last saw the deceased alive on <b>11-4-1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death							
<b>22b SIGNATURE</b> <i>Riccardo U. FRA NCH</i>							
22c. DEGREE ATTENDING PHYS.		22d. ADDRESS 7729 Finch Lane, Lanham, Md.		22e. DATE SIGNED <b>11-4-68</b>			
23a. BURIAL CREMATION REMOVAL (Specify) Burial		23b. DATE Nov 7, 1968		23c. NAME OF CEMETERY OR CREMATORIUM Cedar Hill Cemetery		23d. LOCATION (City or Town) Suitland	(County) Pro Geo (State) Md.
24. FUNERAL DIRECTOR		ADDRESS F. Gasch's Sons Hyattsville, Md.		25a. REC'D BY REGISTRAR NOV 8 1968		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	



**10 HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.  
 Page 4 may be retained by the hospital or attending physician.

**10 FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 4 should be filed with the State Dept. of Health prior to burial, or removal, and in any event, within 72 hours after death.

16388

MARYLAND STATE DEPARTMENT OF HEALTH  
 DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

1640

## CERTIFICATE OF DEATH

1. DECEASED NAME (Type or print)	First Ruth	Middle Elizabeth	Last McKenney	2a. DATE OF DEATH Month Nov.	Day 6	Year 1968	2b. HOUR 6:15AM
3. SEX Female	4. RACE Caucasian	5. DATE OF BIRTH March 29, 1910		6. AGE (In years last birthday) 58	IF UNDER MONTHS YRS	YEAR DAYS	IF UNDER 24 HRS HOURS MIN
7a. BIRTHPLACE (State or foreign country) Washington D C	7b. CITIZEN OF WHAT COUNTRY? U S A	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	9. COUNTY OF DEATH Prince George's	Md			
10. CITY OR TOWN OF DEATH Cheverly	11. NAME OF HOSPITAL OR INSTITUTION (If not a hospital give street address) Prince Geo. Gen'l Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Packer	12b. KIND OF BUSINESS OR INDUSTRY Safeway			
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE Maryland	13b. COUNTY Prince George's	13c. CITY OR TOWN Riverdale	13d. INSIDE CITY J.M.T.S? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 5433 55th Place			
14. FATHER'S NAME Richard E Donaldson	First Middle Last	15. MOTHER'S Maiden Name Emily H Martin	Middle Last				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (Unknown)	16b. SOCIAL SECURITY NO. 577 38 1698	17. INFORMANT Arthur McKenney	Address Greenbelt, Md				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction</u>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) <u>Severe stenosing coronary arteriosclerosis.</u>							
DUE TO, OR AS A CONSEQUENCE OF (c)							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(c) <u>4104</u>							
19a. DATE OF OPERATION MEDICAL CERTIFICATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>yes</u>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH <input type="checkbox"/> If either, notify medical examiner		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No	City or Town	County	State
22a. I certify that (I) <input type="checkbox"/> attended the deceased from <u>2/12/68</u> to <u>Nov. 6, 1968</u> , that (I) <input type="checkbox"/> last saw the deceased alive on <u>Sept. 2, 1968</u> , and that in my <input type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above, (I) <input type="checkbox"/> did / did not view the body after death.							
22b. SIGNATURE <u>George J. Hageage</u>		DEGREE ATTENDING PHYS	<input checked="" type="checkbox"/> MED DIRECTOR	<input type="checkbox"/> STAFF PHYS	22c. DATE SIGNED 11-6-68		
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS 3717 38th Ave., Cottage City, Md. 20722					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE Nov 9, 1968	23c. NAME OF CEMETERY OR CREMATORIUM Ft Lincoln Cemetery	23d. LOCATION (City or Town) Colmar Manor Pro Geo Md.		(County) (State)	
24. FUNERAL DIRECTOR		ADDRESS F. Gasch's Sons Hyattsville, Md.		25a. REC'D BY REGISTRAR DATE NOV 12 1968	25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		



MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

16389

16401

To HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.  
 Page 4 may be retained by the hospital or attending physician.

10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1, 2, 3, 4 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print)		First <b>JAMES</b>	Middle <b>HORACE</b>	Lost <b>MITCHELL</b>	2a. DATE OF DEATH Month <b>NOVEMBER</b>	Year <b>1968</b>	2b. HOUR <b>9:05 A.M.</b>			
3 SEX <b>Male</b>		4. RACE <b>Caucasian</b>		5 DATE OF BIRTH <b>September 9, 1898</b>		6. AGE (In years last birthday) <b>70 yrs</b>	IF UNDER 1 YEAR MONTHS <b>0</b>	IF UNDER 24 HRS HOURS <b>0</b>	MIN <b>00</b>	
7a. BIRTHPLACE (State or foreign country) <b>Tennessee</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH <b>Prince Georges County,</b>				
10. CITY OR TOWN OF DEATH <b>Riverdale</b>		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Leland Memorial Hospital</b>		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>Salesman (retired)</b>		12b KIND OF BUSINESS OR INDSTRY				
13a USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE <b>Maryland</b>		13c. CITY OR TOWN <b>Prince Georges</b>		13d INSIDE CITY LIMIT? <b>YES</b>	13e STREET AND NUMBER <b>5902 31st Avenue</b>					
14 FATHER'S NAME First <b>James</b>		Middle <b></b>	Last <b>Mitchell</b>	15 MOTHER'S MAIDEN NAME First <b></b>		Middle <b></b>	Lost			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <b>No</b>		16b. SOCIAL SECURITY NO. <b>577-30-0929</b>		17 INFORMANT <b>Sister-in-law Mrs. Clara Mitchell</b>		Address <b>4801 Connecticut Ave., NW Washington, D.C.</b>				
18. CAUSE OF DEATH (Enter any one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)		<b>Congestive Heart Failure</b>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>6 weeks</b>				
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost <b>447 X</b>		DUE TO, OR AS A CONSEQUENCE OF <b>Hypertensive (cardiovascular) Disease</b>		DUE TO, OR AS A CONSEQUENCE OF <b>(c)</b>		5 years				
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>Vремя</b>										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, natl. med. coll. examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year PM 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State				
22a. I certify that (I) (this hospital) attended the deceased from <b>1965</b> , to <b>11/23/68</b> , that (I) (we) last saw the deceased alive on <b>11/9/1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <b>P. Colevas</b>		DEGREE <b>ATTENDING PHYS.</b>	<input checked="" type="checkbox"/> MED DIRECTOR	<input type="checkbox"/> STAFF PHYS	22c. DATE SIGNED <b>11/24/68</b>					
22d. PHYSICIAN'S NAME (Type) <b>P. Colevas</b>		22e. ADDRESS <b>3737 Legation St., N. W., Wash., D. C.</b>								
23a. BURIAL, CREMAT. ON, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>11/29/68</b>	23c. NAME OF CEMETERY OR CREMATORIUM <b>Cedar Hill Cemetery</b>		23d. LOCATION (City or Town) <b>Suitland, Prince Georges, Md.</b>		(County) (State)			
24. FUNERAL DIRECTOR <b>Joseph Gawler's Sons, Inc., Washington, D.C.</b>		ADDRESS		25a. REC'D BY REGISTRAR <b>NOV 29 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>				



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word 'pending' in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with the burial permit. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used on a burial/transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

164014

16390

1. DECEASED NAME (Type or Print)		First	Middle	Last	2a. DATE KNOWN OF ESTI. DEATH MATED	Month	Day	Year	2b. HOUR
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	7. IF UNDER 1 YEAR MONTHS      DAYS	8. IF UNDER 24 HRS HOURS      MIN				
Female	Negro	3-10-1905	63 YRS						
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	9. COUNTY OF DEATH	2c. DATE PRONOUNCED DEAD Month Day Year			
South Carolina		USA		WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	Prince George's	11	19	68	19150pm M
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. U.S.A. OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY	
Cheverly		Prince George Hospital							
13a. LOCAL RESIDENCE (Where deceased lived, if institution residence before admission) STATE		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER			
Maryland		Prince George's Seat Pleasant		YES <input type="checkbox"/> NO <input type="checkbox"/>		403 73rd Street			
14. FATHER'S NAME		First	Middle	Last	15. MOTHER'S MAIDEN NAME	First	Middle	Last	
		Willie		Stewart	Mary			McCormick	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO. (If yes give war or dates of service)		17. INFORMANT		ADDRESS			
				Mrs. Rosemary Barnett		-403 73rd St			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									
PART I. DEATH WAS CAUSED BY									
IMMEDIATE CAUSE (a) Heart failure									
DUE TO, OR AS A CONSEQUENCE OF Arteriosclerotic heart disease									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b)									
DUE TO, OR AS A CONSEQUENCE OF									
(c)									
over 5 yrs									
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH minutes									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
Diabetes - over 4 months									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?					
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M.		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No		City or Town	County	State	
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE		<i>John Kehoe</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22b. DATE SIGNED			
EXAMINER'S NAME (Type)		John Kehoe MD		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		11-20-68			
23a. BURIAL, CREMATION REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL Harmony Memorial Park		23d. LOCATION (City or Town) Maryland		(County)	(State)
Burial		11/23/68							
24. FUNERAL DIRECTOR		John T. Stewart		ADDRESS		25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE		
		Stewart Funeral Home-4001 Benning Road, N.E.				Nov 22 1968			



Item5 FilmG 06 11/14/68 MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16475

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if any delay is necessary, please execute the certificate, writing the word pending in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with item 10 PM3 Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial/transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

16391 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. DECEASED NAME (Type or Print)		First	Middle	Last	2a. DATE KNOWN OF ESTI- DEATH MADE <input checked="" type="checkbox"/> 11-6-68 1968 :00am				2b. HOUR		
3. SEX	4. RACE	S. DATE OF BIRTH	6. AGE (in years last birthday)	7. IF UNDER 1 YEAR MONTHS DAYS	8. IF UNDER 24 HRS HOURS MIN						
Female	Negro	5-28-1936 1937	31 yrs								
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	9. COUNTY OF DEATH	2c. DATE PRONOUNCED DEAD Month Day Year				2d. HOUR	
Virginia		USA		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	Prince George's	6 68 1968 30pm M					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)				12b. KIND OF BUSINESS OR INDUSTRY	
Seat Pleasant		7618 F Street, Apt. 203									
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission)		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER					
Maryland		Prince George's Seat Pleasant		YES <input type="checkbox"/> NO <input type="checkbox"/>		7618 F Street, Apt. 203					
14. FATHER'S NAME		First	Middle	Last	15. MOTHER'S MAIDEN NAME		First	Middle	Last		
Crawley Bryant					Ethel		(unknown)				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO. (If yes give war or dates of service)		17. INFORMANT		ADDRESS					
				George Moore		201 Elmira St., S.W.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) <u>Asphyxia</u> 974 DO TO, OR AS A CONSEQUENCE OF <u>Hanging</u> Conditions, if any, which gave rise to immediate cause (o), stating the underlying cause (b) stating the underlying cause (c) DO TO, OR AS A CONSEQUENCE OF (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(o) 974X											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M.		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) home		21f. LOCATION Street or R.F.D. No. _____ City or Town _____ County _____ State _____							
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <u>John Kehoe</u> EXAMINER'S NAME (Type) John Kehoe MD Riverdale, Md.											22b. DATE SIGNED 11-7-68
23a. BURIAL, CREMATION REMOVAL (Specify)		23b. DATE 11/10/68		23c. NAME OF CEMETERY OR CREMATORIAL Carver Cemetery		23d. LOCATION (City or Town) Suffolk, Virginia		(County) (State)			
24. FUNERAL DIRECTOR		ADDRESS Stewart Funeral Home - 4001 Benning Road, N.E.		25a. REC'D BY REGISTRAR NOV 12 1968		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>					



**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the State Dept. at Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

16392

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
CERTIFICATE OF DEATH

16466

1. DECEASED-NAME (Type or print)	First <b>Max</b>	Middle <b>C.</b>	Last <b>Moureau</b>	2a. DATE OF DEATH Month <b>Nov</b> 4, 1968 Day Year	2b. HOUR M
3. SEX <b>male</b>	4. RACE <b>white</b>	5. DATE OF BIRTH <b>July 4, 1892</b>		6. AGE (In years last birthday) <b>76</b> YRS.	IF UNDER 24 HRS MONTHS DAYS HOURS MIN
7a. BIRTHPLACE (State or foreign country) <b>Wisconsin</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH <b>Prince George's</b>	Md	
10. CITY OR TOWN OF DEATH <b>Hyattsville,</b>	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital <b>93919 Oliver St</b>	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>Retired Machinist</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>U.S. Government</b>	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Md</b>	13b. CITY OR TOWN <b>Pro George's</b>	13c. CITY OR TOWN <b>Hyattsville</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER <b>3919 Oliver St</b>	
14. FATHER'S NAME First <b>Max</b>	Middle <b>F</b>	Last <b>Moureau</b>	15. MOTHER'S MAIDEN NAME First <b>Mary B Binger</b>	Middle	Last
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown? <b>No</b>	16b. SOCIAL SECURITY NO <b>579 40 0456</b>	17. INFORMANT <b>Mable Moureau</b>	Address <b>Hyattsville, Md.</b>	APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Congestive Heart Failure</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <i>Cardiovascular Disease</i>					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>4</i>					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No	City or Town	County	State
22a. I certify that (I) (this hospital) attended the deceased from <b>Nov</b> , 19 <b>68</b> , to <b>11-4</b> , 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>11-4</b> 19 <b>68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <i>C. Deitz</i>	23c. DEGREE ATTENDING PHYS	22c. MED. DIRECTOR <input checked="" type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	22d. DATE SIGNED <b>11-5-68</b>	
22d. PHYSICIAN'S NAME (Type) <b>A Deitz</b>	22e. ADDRESS <b>Pro Geo Plaza</b>		Hyattsville, Md.		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>Nov 7, 1968</b>	23c. NAME OF CEMETERY OR CREMATORIUM <b>Ft Lincoln Cemetery</b>	23d. LOCATED ON (City or Town) <b>Colmar Manor</b>	(County) <b>Pro Geo</b>	(State) <b>Md.</b>
24. FUNERAL DIRECTOR <b>F. Gasch's Sons</b>	ADDRESS <b>Hyattsville, Md.</b>	25a. REC'D BY REGISTRAR DATE <b>NOV 8 1968</b>	25b. REGISTRAR'S SIGNATURE <i>Charles J. Geiger</i>		



Item 18 Film 408 1/8 MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

1040

FOR STATE  
HEALTH DEPT.

16393

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "Pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with farm PM3. Page 5 may be retained for your files.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. DECEASED NAME (Type or Print)		First	Middle	Last	2a. DATE KNOWN OF ESTI. DEATH MATED	Month	Day	Year	2b. HOUR		
3. SEX	4. RACE	S. DATE OF BIRTH	6 AGE (in years last birthday)	IF UNDER 1 YEAR MONTHS      DAYS	IF UNDER 24 HRS HOURS      MIN.	11-17-68			10:15am		
Female	White	5-30-1934	34 yrs			2c. DATE PRONOUNCED DEAD	Month	Day	Year		
7a. BIRTHPLACE (State or foreign country)		7b. CIT.ZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH			2d. HOJR		
Kentucky		USA				Prince George's			Md.		
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY			
Riverdale		Belmont Memorial Hospital			Housewife			House			
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission)		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS	13e. STREET AND NUMBER						
Maryland		Prince George's Beltsville		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	4305 Birmingham Place						
14. FATHER'S NAME		First	Middle	Last	15. MOTHER'S MAIDEN NAME	First	Middle	Last			
Rupert C Weddle					Laura Jane Price						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
No		(If yes give war or dates of service)		Charles Murphy - Aban							
18. CAUSE OF DEATH (Enter any one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY.		IMMEDIATE CAUSE (a) Acute pulmonary edema									
X		DUE TO, OR AS A CONSEQUENCE OF									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		Acute viral myocarditis								days	
		DUE TO, OR AS A CONSEQUENCE OF									
		(c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
131X		2 months pregnancy									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY?	
										YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month Day, Year HOUR A.M. P.M.		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No.		City or Town	County	State			
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>										22b. DATE SIGNED	
ACTUAL SIGNATURE		John Kehoe MD								11-18-68	
EXAMINER'S NAME (Type)		Riverdale, Md.								ADDRESS (Street, city, town, or county)	
23a. BURIAL, CREMATION REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS		23d. LOCATION (City or Town)		County	(State)		
Burial 11-21-68 Greenwood Cemetery, Liberty, Kentucky											
24. FUNERAL DIRECTOR		25a. REC'D BY REGISTRAR								25b. REGISTRAR'S SIGNATURE	
Marineau Funeral Home, Riverdale, Md.		Noy Nov 4 1968									



## MARYLAND STATE DEPARTMENT OF HEALTH

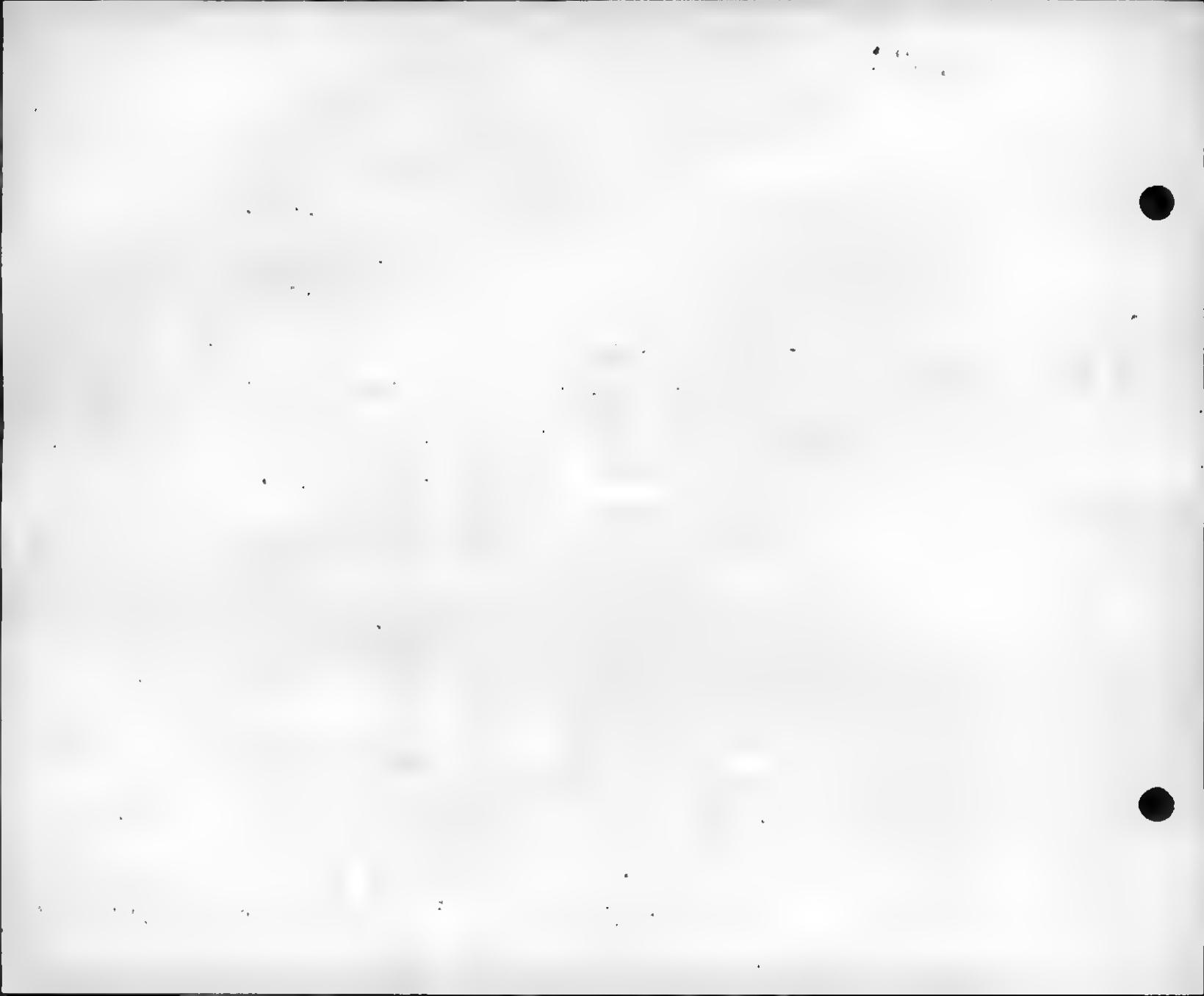
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16411

## CERTIFICATE OF DEATH

**HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.  
**FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician or director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print)				First	Middle	Last	2a. DATE OF DEATH Month	Year	2b. HOUR 9:45AM			
Raymond				T.	Nair	11-	14-68					
3 SEX Male		4. RACE White		5. DATE OF BIRTH 3-1-09			6 AGE (in years last birthday) 59 YRS.		IF UNDER 1 YEAR MONTHS	IF UNDER 24 HRS. DAYS	HOURS	MIN
7a. BIRTHPLACE (State or foreign country) Virginia		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH Prince George		Md			
10. CITY OR TOWN OF DEATH Riverdale		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Eugene Leland Memorial			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) CARPENTER			12b. KIND OF BUSINESS OR INDUSTRY				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. CITY OR TOWN Prince George		13c. CITY OR TOWN Hyattsville		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 4002 Oliver St.,				
14. FATHER'S NAME Franklin		First Middle Nair		15. MOTHER'S MAIDEN NAME Mary			16. SPOUSE'S NAME SUSAN Smith					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown NO		16b. SOCIAL SECURITY NO. 225-124850		17. INFORMANT Spouse and Medical Records			Address					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>41dx</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), (b) <u>storing the underlying cause</u> DUE TO, OR AS A CONSEQUENCE OF lost. (c)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 MIN
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)												UNKNOWN
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County		State		
22a. I certify that (I) (this hospital) attended the deceased from <u>2 FEB</u> , 19 <u>65</u> , to <u>14 NOV</u> , 19 <u>68</u> , that (II) (we) last saw the deceased alive on <u>14 NOV</u> 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) <input checked="" type="checkbox"/> (did not) view the body after death.												
22b. SIGNATURE <u>C. J. Houmann</u>		22c. DATE SIGNED <u>14 NOV 1968</u>		22d. DEGREE ATTENDING PHYS.		MED. DIRECTOR		STAFF PHYS.				
22d. PHYSICIAN'S NAME (Type) C. J. Houmann, M.D.		22e. ADDRESS 4408 Queensbury Rd., Riverdale, Md.										
23a. BURIAL, CREMATION REMOVAL (Specify) BURIAL		23b. DATE NOV. 16, 1968		23c. NAME OF CEMETERY OR CREMATORIAL FORT LINCOLN CEM.		23d. LOCATION (City or Town) COLMAR MANOR, MARYLAND		(County)		(State)		
24. FUNERAL DIRECTOR W. W. CHAMBERS		ADDRESS C. RIVERDALE, MD.		25a. RECD BY REGISTRAR DATE NOV 18 1968		25b. REGISTRAR'S SIGNATURE <u>John J. Chambers</u>						



MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16409

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in, direct to page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

16395

**CERTIFICATE OF DEATH**

1. DECEASED-NAME (Type or print)		First Olga	Middle M.	Last Nelson	2a. DATE OF DEATH Hour Month Day Year 12 Day 1968	2b. HOUR 12 PM	
3. SEX Female		4. RACE White		S. DATE OF BIRTH 1-16-1898	6. AGE (In years lost birthday) 70 YRS.	F. UNDER 1 YEAR MONTHS DAYS	I. F. UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (State or foreign country) Minnesota		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Pr. Geo.		
10. CITY OR TOWN OF DEATH Oxon Hill		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 5634 Fargo Ave.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE Md.		13b. CITY OR TOWN Pr. Geo.		13c. CITY OR TOWN Oxon Hill	3d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER 5634 Fargo Ave.	
14. FATHER'S NAME Michael		Middle Fricker	Last	15. MOTHER'S MAIDEN NAME unknown	Middle	Last Moyer	
16a. WAS DECEDENT EVER IN U.S. ARMED FORCES? Yes, no, or unknown No		16b. SOCIAL SECURITY NO.		17. INFORMANT Clarine Penewell	Address 5634 Fargo Ave.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) <b>PART I DEATH WAS CAUSED BY.</b> <b>IMMEDIATE CAUSE (a)</b> <i>Ingestion Head injuries</i> APPROXIMATE INTERVAL <b>BETWEEN ONSET AND DEATH</b> <i>19 yrs</i> <b>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b)</b> <i>Generalized Arteriosclerosis</i> <b>20 yrs</b> <b>DUE TO, OR AS A CONSEQUENCE OF</b> <b>(b)</b> <i>Generalized Arteriosclerosis</i> <b>DUE TO, OR AS A CONSEQUENCE OF</b> <b>(c)</b>							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.	City or Town	County	State
22a. I certify that (I) (this hospital) attended the deceased from <i>Jan 1968</i> , to <i>Nov 12, 1968</i> , that (I) (we) last saw the deceased alive on <i>July 1968</i> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>Eugene J. Yarchoff MD</i>		DEGREE ATTENDING PHYS	<input checked="" type="checkbox"/> MED DIRECTOR	<input type="checkbox"/> STAFF PHYS.	22c. DATE SIGNED <i>11/14/68</i>		
22d. PHYSICIAN'S NAME (Type) <i>E.J. Yarchoff</i>		22e. ADDRESS <i>2704 Riviera St. Suitland St. Md.</i>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Natural</i>		23b. DATE <i>11-15-68</i>	23c. NAME OF CEMETERY OR CREMATORIAL <i>Arlington National Cem.</i>		23d. LOCATION (City or Town) <i>Arlington</i>	(County) <i>Va.</i>	(State)
24. FUNERAL DIRECTOR Wilhelm Funeral Home 4308 Suitland Rd. S. E. Suitland, Md.		ADDRESS <i>4308 Suitland Rd. S. E. Suitland, Md.</i>		25a. REC'D BY REGISTRAR <i>NOV 20 1968</i>	25b. REGISTRAR'S SIGNATURE <i>W. Wilhelm</i>		



MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

164-11

16396

1 To HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be signed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

To FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper pages 1 and 2, which should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

1. DECEASED NAME (Type or print)		First  Mary	Middle  (NMI) Noteware	Lost	2a. DATE OF DEATH Month 11 Day 15 Year 68	2b. HOUR 550P M
3 SEX  Female	4 RACE  <i>White</i>	5. DATE OF BIRTH  15 Nov 1968		6. AGE (In years lost birthday - YRS.)  - 5	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN 0 0 0 0	IF UNDER 24 HRS. MONTHS DAYS HOURS MIN 0 0 0 0
7a. BIRTHPLACE (State or foreign country)  Maryland	7b. CITIZEN OF WHAT COUNTRY?  USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH  Prince Georges County		
10. CITY OR TOWN OF DEATH  Andrews AFB	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)  Malcolm Grow USAF Hospital	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)  Infant	12b. KIND OF BUSINESS OR INDUSTRY  infant			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md	13c. CITY OR TOWN Prince Georges	13d. INSHOE CITY J.M.T.S? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER 2084 Addison Rd, Apt 1			
14. FATHER'S NAME  Carson W NoteWare	First  Middle  Last	15. MOTHER'S MAIDEN NAME  Carol L Hansen	First  Middle  Last			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown no	16b. SOCIAL SECURITY NO.  none	17. INFORMANT  Father	Address  2084 Addison Rd, District Hgts			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)  <i>7762</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
(b) <i>Deep arrest</i> DUE TO, OR AS A CONSEQUENCE OF lost						
(c) <i>Prenatality</i>						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)						
MEDICAL CERTIFICATION		19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?  YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?  yes	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)	21f. LOCATION Street or R.F.D. No	City or Town	County	State
22a. I certify that (I) (this hospital) attended the deceased from <u>15 Nov</u> , 1968, to <u>15 Nov</u> , 1968, that (I) (we) last saw the deceased alive on <u>15 Nov</u> , 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (do not) view the body after death.						
22b. SIGNATURE  <i>James E. Willard</i>		DEGREE  ATTENDING PHYS	MED. DIRECTOR <input checked="" type="checkbox"/>	STAFF PHYS <input type="checkbox"/>	22c. DATE SIGNED  <u>15 Nov 68</u>	
22d. PHYSICIAN'S NAME (Type)  James E. Willard		22e. ADDRESS  Malcolm Grow USAF Hospital				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE  11-21-68	23c. NAME OF CEMETERY OR CREMATORIAL  <i>Tulsa Cemetery</i>	23d. LOCATION (City or Town)  <i>Tulsa Oklahoma</i>	(County)  <i>Oklahoma</i>	(State)  <i>Oklahoma</i>
24. FUNERAL DIRECTOR  <i>W.W. Chambers</i>		ADDRESS  517 1/2 St. SE	25a. REG'D BY REGISTRAR  <i>W.W. Chambers</i>	25b. REGISTRAR'S SIGNATURE  <i>W.W. Chambers</i>	DATE  <u>Nov 22 1968</u>	



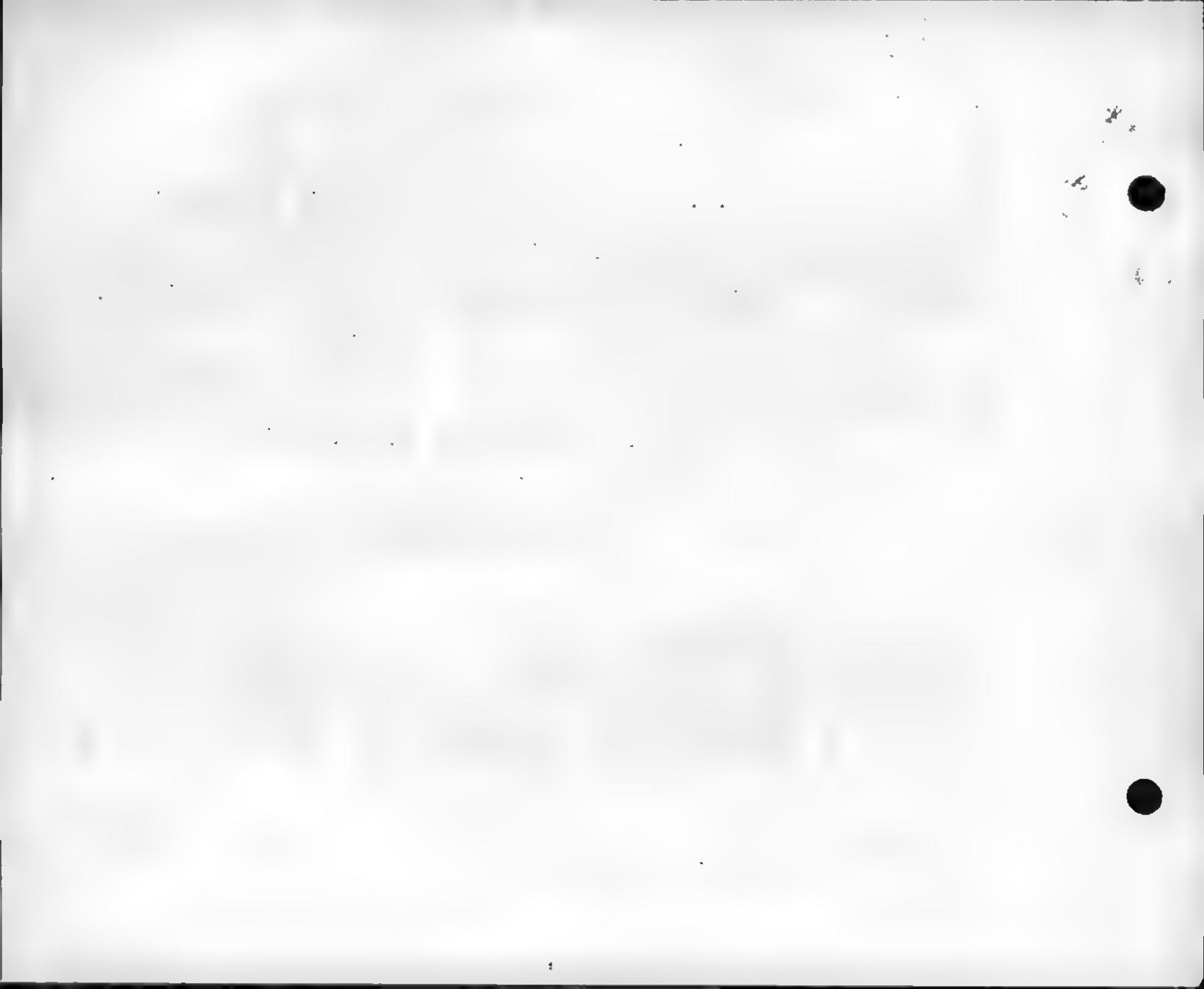
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

164

CERTIFICATE OF DEATH

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.  
 Page 4 may be retained by the hospital or attending physician.  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print)		First <b>SUSIE</b>	Middle <b>C</b>	Last <b>NOWOSACKI</b>	2a. DATE OF DEATH <b>NOV Month 18 Day 1968</b>	2b. HOUR <b>2215 M</b>	
3. SEX <b>Female</b>		4. RACE <b>Caucasian</b>		5. DATE OF BIRTH <b>25 Oct 1921</b>	6. AGE (In years last birthday) <b>47</b>	IF UNDER 1 YEAR <b>YRS.</b>	
7a. BIRTHPLACE (State or foreign country) <b>Alabama</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH <b>Prince George's</b>		
10. CITY OR TOWN OF DEATH <b>Andrews AFB</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Malcolm Grow USAF Hosp</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Secretary</b>	12b. KIND OF BUSINESS OR INDUSTRY <b>Fed. Gov.</b>		
13a. USUAL RESIDENCE (Where deceased lived, if institution address) STATE <b>Maryland</b>		13c. CITY OR TOWN <b>Prince Georges Oxon Hill</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER <b>4401 Eugenia St.</b>		
14. FATHER'S NAME First <b>Sam</b>		15. MOTHER'S MAIDEN NAME First <b>Carruba</b>		16. ADDRESS <b>Susie C ?</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <b>No</b>		16b. SOCIAL SECURITY NO <b>423140771</b>		17. INFORMANT <b>Husband Same as item # 13</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) <b>PART I. DEATH WAS CAUSED BY.</b> <b>IMMEDIATE CAUSE (a)</b> <b>Pulmonary Metastases and Insufficiency</b> 2 weeks <b>DUE TO, OR AS A CONSEQUENCE OF</b> <b>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause</b> <b>Oat Cell carcinoma of lung</b> 11 weeks <b>(b)</b> <b>DUE TO, OR AS A CONSEQUENCE OF</b> <b>(c)</b>						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)							
20. DATE OF OPERATION <b>17 Sep 68</b>		20b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Hepatomegaly</b>		20c. AUTOPSY? <b>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></b>	20d. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No	City or Town	County	State	
22a. I certify that <input type="checkbox"/> (this hospital) attended the deceased from <b>30 Oct 1968</b> , to <b>18 Nov 1968</b> , that <input type="checkbox"/> (we) last saw the deceased alive on <b>18 Nov 1968</b> and that in <input type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input type="checkbox"/> (we) <input type="checkbox"/> (did not) view the body after death.							
22b. SIGNATURE <i>David Rosenthal</i>		DEGREE <b>PHYS</b>	ATTENDING <input type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS <input checked="" type="checkbox"/>	22c. DATE SIGNED <b>18 Nov 68</b>	
22d. PHYSICIAN'S <b>DAVID S ROSENTHAL, MAJ USAF MC</b>		22e. ADDRESS <b>MALCOLM GROW USAF HOSP ANDREWS AFB</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>11-22-68</b>	23c. NAME OF CEMETERY OR CREMATORIAL <b>Arlington National</b>		23d. LOCATION (City or Town) <b>Arlington</b>	(County) <b>Va.</b>	(State)
24. FUNERAL DIRECTOR <b>Wilhelm Funeral Home 4308 Suitland Rd. Suitland, Md.</b>		ADDRESS	25a. REG'D BY REGISTRAR <b>NOV 25 1968</b> 25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>				



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2 and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with farm PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 DECEASED NAME (Type or Print)		First Michael	Middle Edward	Last O'Connor	2a DATE KNOWN OF DEATH MATED <input checked="" type="checkbox"/>	Month 11	Day 24	Year 1968	2b HOUR 6:05 am
3 SEX Male	4 RACE White	5 DATE OF BIRTH 8-3-1908	6 AGE (In years last birthday) 60	7 MONTHS YRS	8 IF UNDER 1 YEAR MONTHS	9 IF UNDER 24 HRS DAYS	10 MIN		2d. HOUR
7a BIRTHPLACE (State or foreign country) W. Va.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		9 WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		10 COUNTY OF DEATH Cheverly	
								Prince George's	
11 CITY OR TOWN OF DEATH Cheverly		11 NAME OF HOSPITAL OR INSTITUTION (If not in hosp to give street address) Prince George Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, institution Residence before admission) STATE Maryland		13c. CITY OR TOWN Prince George's		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 15616 Old Chapel Road			
14 FATHER'S NAME Martin		15. MOTHER'S MAIDEN NAME O'Connor		16. ADDRESS 3811 - Riverport St., Md.					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16b SOCIAL SECURITY NO. - - -		17. INFORMANT Carmen K. O'Connor					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Heart failure		19. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH over 5 yrs.							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost		DUE TO, OR AS A CONSEQUENCE OF Arteriosclerotic heart disease							
(b)		DUE TO, OR AS A CONSEQUENCE OF							
(c)									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
20c. MEDICAL CERTIFICATION		19c. DATE OF OPERATION		19d. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day Year HOUR A.M. P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No		City or Town		County State	
22o. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE <i>John Kehoe</i>				CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22b. DATE SIGNED 11-25-68	
EXAMINER'S NAME (Type) John Kehoe MD		Riverdale, Md.							
23a. BURIAL CREMATION, REMOVAL (Specify) - - -		23b. DATE 11/27/68		23c. NAME OF CEMETERY OR CREMATORIAL Ft. Lincoln Cem.		23d. LOCATION (City or Town) Colmar Manor, Md.		(County) (State)	
24. FUNERAL DIRECTOR (Name) Falls Funeral Home Inc.		ADDRESS Mt. Rainier Md.		25a. REC'D BY REGISTRAR NOV 29 1968		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		DATE	



13415

## **CERTIFICATE OF DEATH**

DECEASED NAME (Type or print)		First	Middle	Last	2a DATE OF DEATH Month Day Year	2b HOUR 6:45 AM
Mary E.		O'Donnell		Nov. 25 1968	25	1968
3. SEX	4. RACE	S. DATE OF BIRTH		6. AGE (In years last birthday)	IF UNDER 1 YEAR	
Female	W	2/22/66		70	MONTHS	YEARS
7b. BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> W.DOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH	
DC.		U.S.		Prince Georges		
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b KIND OF BUSINESS OR INDUSTRY
Forestville		The Regent Rehab. Center.		retired		re-s-gar.
13a USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE		13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e STREET AND NUMBER	
Md.		Crown Hill		YES <input type="checkbox"/>	1921 Owens Road.	
14. FATHER'S NAME First		Middle	Last	15. MOTHER'S MAIDEN NAME First		Middle
Patrick O'Donnell				Eunice Boyle		Lost
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO		17. INFORMANT		Address
(If yes give rank or dates of service)						7 Penna
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))  PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)		DUE TO, OR AS A CONSEQUENCE OF  (b) A.S.H.C.V.D. and extensive CVA				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
4 /		Respiratory arrest				5 min.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last		DUE TO, OR AS A CONSEQUENCE OF  (c)				5 mos.
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(c)						
+ + +						
19a. DATE OF OPERATION	19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner)	21b TIME OF INJURY HOUR A.M. Month Day Year P.M.	21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)				
19						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f LOCATION Street or R.F.D. No	City or Town	County	State	
22a I certify that (I) (this hospital) attended the deceased from <u>July</u> , 1968, to <u>Nov. 25</u> , 1968, that (I) (we) last saw the deceased alive on <u>Nov. 18</u> , 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death						
22b. SIGNATURE F. Joseph Weber, M.D.		DEGREE	ATTENDING PHYS	<input checked="" type="checkbox"/> MED. DIRECTOR	<input type="checkbox"/> STAFF PHYS	22c. DATE SIGNED 11-25-68
22d. PHYSICIAN'S NAME (Type)	F. JOSEPH WEBER		22e. ADDRESS 3230 Penna Ave. SE.			
23a. BURIAL CREMATION, REMOVAL (Type)	23b. DATE Nov. 27-68	23c. NAME OF CEMETERY OR CREMATORIAL Ceadr Hill Cemetery	23d. LOCATION (City or Town) Suitland, Maryland	(County)		(State)
24. FUNERAL DIRECTOR Simmons Bros.	ADDRESS 1661-Gd. Hope Rd. SE Wash., DC	25a. REC'D BY REGISTRAR NOV 27 1968	25b. REGISTRAR'S SIGNATURE Charles Judge			

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

**HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by you or your attorney or guardian pro tempore, this certificate should be detached from the burial-transit permit. Then please remove carbon papers from page 3 and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours.



MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 1641

CERTIFICATE OF DEATH

16400

**10 HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.  
**Page 4** may be retained by the hospital or attending physician.  
**10 FUNERAL DIRECTOR:** After this cert. f.cate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

1 DECEASED NAME (Type or print)		First <b>SEIKO</b>	Middle <b>PALUBINSKY</b>	Last	2a DATE OF DEATH NOVEMBER 2 1968	2b HOUR 9:22 PM				
3 SEX <b>FEMALE</b>		4. RACE <b>MONGOLIAN</b>		S. DATE OF BIRTH <b>22 FEB 1926</b>	6. AGE (In years last birthday) <b>42</b>	IF UNDER 1 YEAR MONTHS <b>0</b>	IF UNDER 24 HRS. MONTHS <b>0</b>	2b. HOUR HOURS <b>9:22</b>	MIN. <b>00</b>	
7a BIRTHPLACE (State or foreign country) <b>JAPAN</b>		7b CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9 COUNTY OF DEATH <b>PRINCE GEORGE'S</b>					
10d CITY OR TOWN OF DEATH <b>ANDREWS AFB</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>MALCOLM GROW USAF HOSP</b>		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>HOUSEWIFE</b>		12b KIND OF BUSINESS OR INDUSTRY				
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before adm.) <b>DELAWARE</b>		13c CITY OR TOWN <b>KENT COUNTY</b>	13d INSIDE CITY LIMITS? <b>DOVER AFB</b>	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e STREET AND NUMBER <b>1033 C, 2nd AVE.</b>					
14 FATHER'S NAME First <b>TOSHIKO</b>		Middle <b>SAITO</b>	Last	15 MOTHER'S MAIDEN NAME First <b>YOSHIKO</b>	Middle	Last <b>SHIBUE</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? <b>Yes</b>		16b SOCIAL SECURITY NO.		17 INFORMANT <b>HUSBAND SAME AS # 13</b>	Address					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <i>metastatic carcinoma cervix</i>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH						
180 X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c)								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? <b>YES</b> <input checked="" type="checkbox"/> <b>NO</b> <input type="checkbox"/>	20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY OFFICE BUILDING, ETC)		21f LOCATION Street or R.F.D. No	City or Town	County	State			
22a. I certify that (I) (this hospital) attended the deceased from <b>14 OCT 1968</b> , to <b>2 NOV 1968</b> , that (I) (we) last saw the deceased alive on <b>2 NOV 1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b SIGNATURE <i>Cecil E. White M.D.</i>		DEGREE <b>MAJ, USAF, MC</b>	ATTENDING PHYS. <input type="checkbox"/>	MED DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input checked="" type="checkbox"/>	22c DATE SIGNED <b>2 NOV 68</b>				
22d PHYSICIAN'S NAME (Type) <b>CECIL E. WHITE, MAJ, USAF, MC</b>		22e ADDRESS <b>MALCOLM GROW USAF HOSPITAL ANDREWS AFB, WASH, D.C. 20331</b>								
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b DATE <b>11-5-68</b>	23c NAME OF CEMETERY OR CREMATORIAL Funeral <b>Removed by Oravitz &amp; Sons</b>	23d LOCATION (City or Town) <b>Shenandoah, Penna.</b>	(County) <b>Penna.</b>		(State)			
24 FUNERAL DIRECTOR <b>Wilhelm Funeral Home 4308 Suitland Rd. S. E.</b>		ADDRESS	25a REC'D BY REGISTRAR <b>NOV 6 1968</b>			25b REGISTRAR'S SIGNATURE <i>Charles Judge</i>				
VR A15 (4) 30M REV 1/68		DATE <b>NOV 6 1968</b>								



MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

1641:

16401

CERTIFICATE OF DEATH

**10 HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.  
**Page 4** may be retained by the hospital or attending physician.  
**10 FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers pages 1 and 2 and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print)		First  Anna	Middle  Paulkovich	Lost	2d. DATE OF DEATH Month Nov. Day 20, Year 1968	2b. HOUR 9:15PM
3 SEX  Female	4 RACE  Caucasian	5 DATE OF BIRTH  10/2/1881		6. AGE (In years last birthday)  87	IF UNDER 1 YEAR MONTHS YRS	IF UNDER 24 MRS HOURS MIN
7a BIRTHPLACE (State or foreign country)  Austria	7b CITIZEN OF WHAT COUNTRY?  U S A	8 MARRIED <input type="checkbox"/> NEVER MARR ED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH  Prince George's		
10 CITY OR TOWN OF DEATH  Cheverly	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)  Prince Geo. Gen'l Hospital		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)  Housewife	12b KIND OF BUSINESS OR INDUSTRY  Home		
13a USUAL RESIDENCE (Where deceased lived, if institution Res dence before admission) STATE  Maryland	13b CO. COUNTY  Prince George's	13c CITY OR TOWN  Lanham	13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER  6601 Oak Lane		
14 FATHER'S NAME First  Mike Stanasic	Middle  	Lost	15 MOTHER'S MAIDEN NAME First  Barbara Zilich	Middle	Lost	
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown  no	16b SOCIAL SECURITY NO (If yes give war or dates of service)		17 INFORMANT  John Paulkovich	Address  Lanham, Md.		
18 CAUSE OF DEATH (Enter only one cause per line for (a) (b) and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Respiratory failure</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) <i>Respiratory acidosis</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Chronic bronch. pulmonary disease</i>						
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH						
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)  <i>Atherosclerotic heart disease</i>						
19b. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) (OFFICE BUILDING ETC)	21f. LOCATION Street or R.F.D. No	City or Town	County	State	
22a I certify that (I) <del>the hospital</del> attended the deceased from <u>10-19</u> , 19 <u>68</u> , to <u>11-20</u> , 19 <u>68</u> , that (I) <del>saw</del> last saw the deceased alive on <u>11-20</u> , 19 <u>68</u> , and that in my <del>opinion</del> death occurred on the date and hour and from the causes stated above, (I) <del>we</del> (did) <del>not</del> view the body after death.						
22b. SIGNATURE  <i>Fidel J. Quintanis</i>	DEGREE ATTENDING PHYS	<input type="checkbox"/> MED DIRECTOR	<input type="checkbox"/> STAFF PHYS	22c. DATE SIGNED  11-21-68		
22d. PHYSICIAN'S NAME (Type)  <i>Fidel J. Quintanis</i>	22e. ADDRESS  8715 FIRST AVE, SPRING, MD.					
23a BURIAL, CREMATION, REMOVAL (Specify)  Burial	23b DATE  11/23/68	23c NAME OF CEMETERY OR CREMATORIAL  Parklawn Cemetery	23d LOCATION (City or Town)  Rockville	(County)  Montgomery	(State)  Md.	
24 FUNERAL DIRECTOR  <i>F. Gasch's Sons</i>	ADDRESS  Hyattsville, Md.	25a. REC'D BY REG STAR DATE NOV 25 1968				
				25b. REGISTRAR'S SIGNATURE  <i>J. C. G. 11-21-68</i>		

2011

## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16408

Iters 6 Film G 407 12/6/68 1lw CERTIFICATE OF DEATH

**10 HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.**10 FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in, page 4 may be retained by the hospital or attending physician. Director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 DECEASED-NAME (Type or print)	First	Middle	Last	2a. DATE OF DEATH Nov Month 24 Day 1968 Year 1968	2b. HOUR 10 AM
2 SEX Female	4. RACE White	5. DATE OF BIRTH May 29/1898	6 AGE (In years last birthday) 80 yrs	7f. UNDER 1 YEAR MONTHS DAYS	7f. UNDER 24 HRS HOURS MIN
7d. BIRTHPLACE (State or foreign country) Virginia	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8 MARRIED <input checked="" type="checkbox"/> DIVORCED	9. COUNTY OF DEATH Pr. Georges	Md	
10 CITY OR TOWN OF DEATH Gaithersburg	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital gives street address) 16112 Laurel Ridge Dr.	12a. US-JAL OCCUPATION (Kind of work done during most of working life, even if retired) Housewife	12b. KIND OF BUSINESS OR INDUSTRY Home		
13a. US-JAL RESIDENCE (Where deceased lived, if institution, Residence before admission) STATE MD	13b. COUNTY Prince George's Co., Maryland	13c. CITY OR TOWN Laurel	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER 16112 Laurel Ridge Rd	Drive
14 FATHER'S NAME Alfred	First Middle Last Conner	15. MOTHER'S MAIDEN NAME Elizabeth	Address Mrs. Jean Parezo	Cary	Last X-APPENDIX
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, if unknown	16b. SOCIAL SECURITY NO None	17. INFORMANT Mrs. Jean Parezo	APPROXIMATE INTERVAL BETWEEN DEATH AND DEATH 6 Wks.		
18. CAUSE OF DEATH (Enter on a separate line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> 4334 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b). DUE TO, OR AS A CONSEQUENCE OF lost. (c)					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)					
19a. MEDICAL CERTIFICATION DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)		
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County
22a. I certify that (I) (this hospital) attended the deceased from Oct 4, 1968, to Nov 27, 1968, that (I) (we) last saw the deceased alive on Nov 23, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Robert S. McCaney		DEGREE ATTENDING PHYS	<input checked="" type="checkbox"/> MED. DIRECTOR	<input type="checkbox"/> STAFF PHYS	22c. DATE SIGNED 11/27/68
22d. PHYSICIAN'S NAME (Type) Robert S. McCaney		22e. ADDRESS 402 Main St. Laurel, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 11-27-1968	23c. NAME OF CEMETERY OR CREMATORIAL Arlington National Cem.	23d. LOCATION (City or Town) Arlington, Virginia	(County)	(State)
24. FUNERAL DIRECTOR Burial M.A. Dugay Warren E. Pumphrey, Inc.		ADDRESS Sil. Spr. Md. 8434 Georgia Avenue	25a. REC'D BY REGISTRAR NOV 29 1968	25b. REGISTRAR'S SIGNATURE Charles Judge	



Item13 Film3407 12/12/78 MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

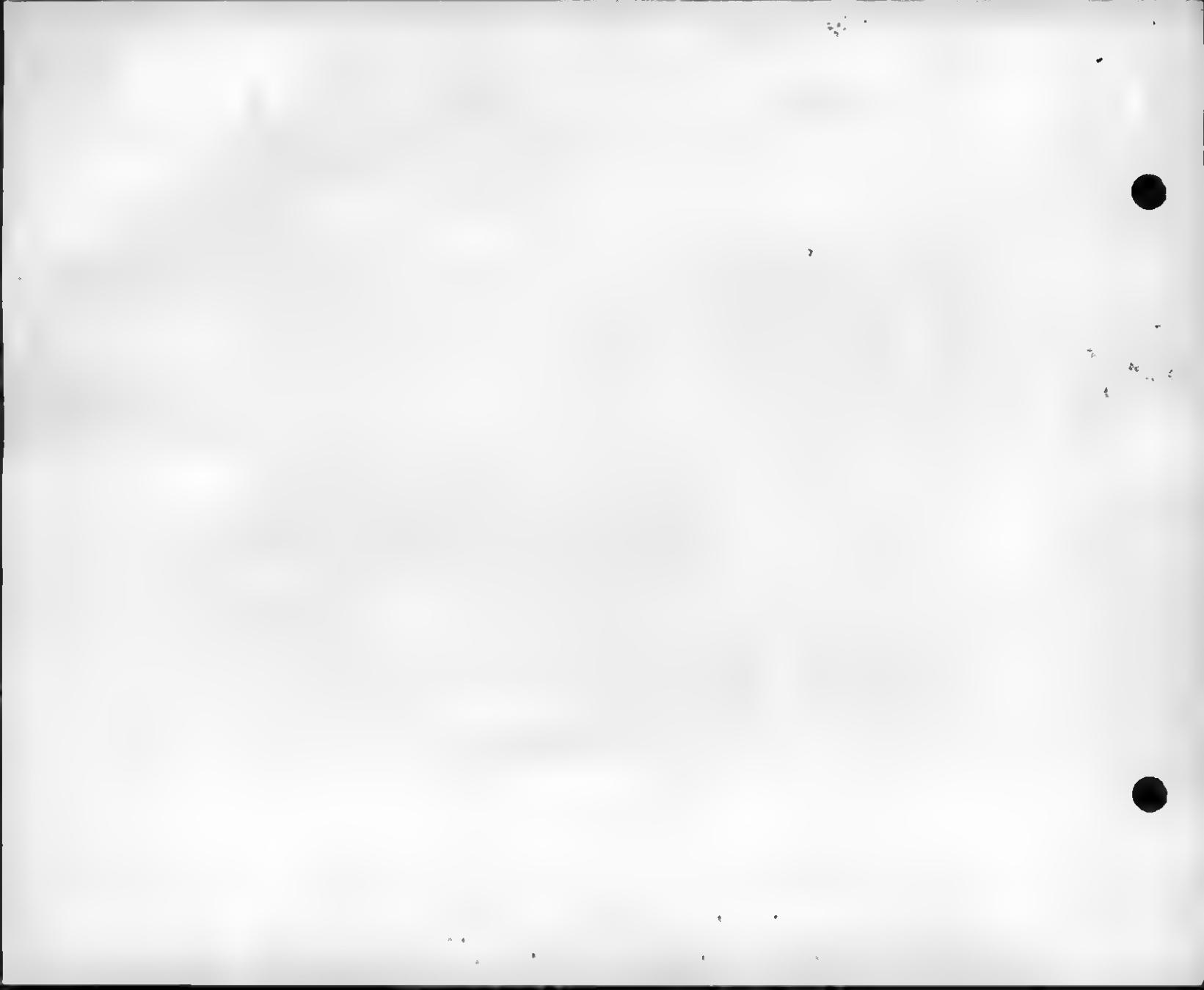
1541

16408 Frederick

CERTIFICATE OF DEATH

**10 HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.  
**Page 4 may be retained by the hospital or attending physician**  
**10 FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician or director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print)	First <i>Frederick</i>	Middle <i>B.</i>	Last <i>Potts</i>	2a DATE OF DEATH Month <i>11</i>	Day <i>22</i>	Year <i>68</i>	2b HOUR <i>7:25 P.M.</i>				
3. SEX <i>Male</i>	4. RACE <i>White</i>	S. DATE OF BIRTH <i>April 5-1886</i>	6. AGE (in years last birthday) <i>82 yrs</i>	7. IF UNDER 1 YEAR MONTHS <i>0</i>	8. IF UNDER 24 HRS. DAYS <i>0</i>	9. IF UNDER 24 HRS. HOURS <i>0</i>	10. IF UNDER 24 HRS. MIN <i>0</i>				
7a. BIRTHPLACE (State or foreign country) <i>Pa</i>	7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	9. COUNTY OF DEATH <i>Pr. Georges</i>	Md.							
10. CITY OR TOWN OF DEATH <i>Forestville</i>	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Regent Nursing Home</i>	12a. USUAL OCCUPATION (Kind of work done during most of work or life, even if retired) <i>Retired</i>	12b. KIND OF BUSINESS OR INDUSTRY <i>Wash Navy yard</i>								
13a. USUAL RESIDENCE (Where deceased lived if institution: Residence before admission) <i>Md.</i>	13b. COUNTY <i>Pr. Georges</i>	13c. CITY OR TOWN <i>Forestville</i>	13d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	13e. STREET AND NUMBER <i>3411 Lorrie Jr.</i>	14. FATHER'S NAME First <i>William A.</i>	Middle <i>Potts</i>	Last <i>Anna Brant</i>	15. MOTHER'S MAIDEN NAME First <i>Jessie or Powell</i>	Address <i>Bl-7304 Justice St.</i>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) <i>No</i>	16b. SOCIAL SECURITY NO. <i>(If yes give war or dates of service)</i>	17. INFORMANT <i>H.H.</i>	APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>15 min.</i>								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Acute Coronary Thrombosis</i> DUE TO, OR AS A CONSEQUENCE OF Conditions if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Arteriosclerotic Heart Disease</i> DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>H.I.</i>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY OFFICE BUILDING, ETC.)			21f. LOCATION Street or RFD No.	City or Town		County	State		
22a. I certify that (H) (this hospital) attended the deceased from <i>July 6</i> , 1966, to <i>11-22</i> , 1968, that (H) (we) last saw the deceased alive on <i>11-22</i> , 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (H) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>W.B. Sheer M.D.</i>		22c. DATE SIGNED <i>11-22-68</i>									
22d. PHYSICIAN'S NAME (Type) <i>WALTER B. SHEER</i>		22e. ADDRESS <i>6400 Maryland Line S.E. Wash. D.C.</i>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>Nov. 26, 68</i>		23c. NAME OF CEMETERY OR CREMATORIUM <i>Cedar Hill Cemetery</i>		23d. LOCATION (City or Town) <i>Suitland, Maryland</i>		(County) (State)			
24. FUNERAL DIRECTOR <i>Simmons Bros.</i>		ADDRESS <i>1661-Gd. Hope Rd. SE. DC.</i>		25a. REC'D BY REGISTRAR <i>Wash.</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		DATE <i>NOV 26 1968</i>			



## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
Items #14 & 15 taken from birth cert. 16405

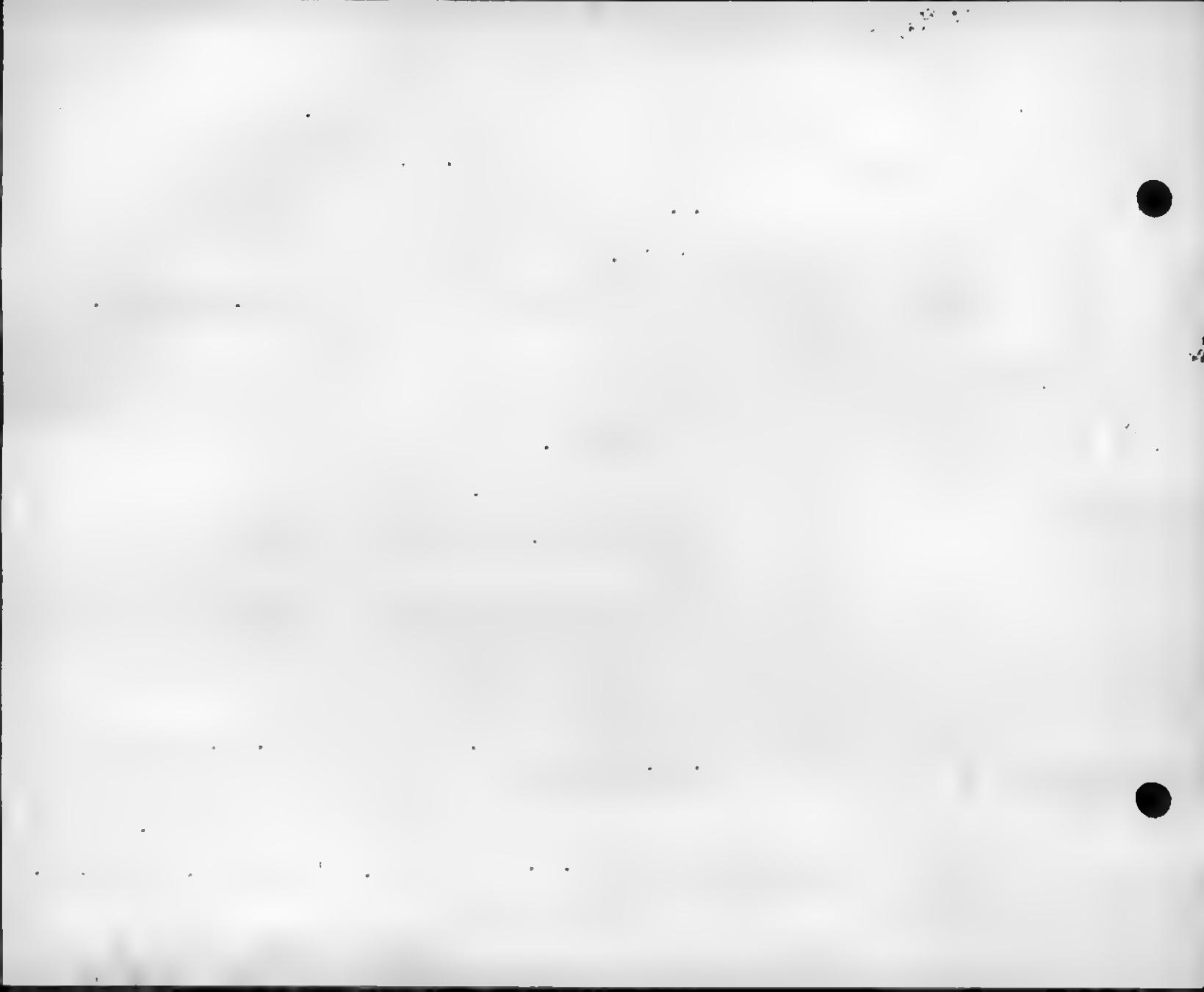
## CERTIFICATE OF DEATH

1641

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 DECEASED-NAME (Type or print)	First <b>Jerome</b>	Middle <b>Anthony</b>	Last <b>Proctor</b>	2d. DATE OF DEATH Month <b>Nov.</b> Day <b>24,</b> Year <b>1968</b>	2b. HOUR <b>4:30 PM</b>
3 SEX <b>Male</b>	4. RACE <b>Negroid</b>	S DATE OF BIRTH <b>Sept. 26, 1968</b>	6 AGE (In years last birthday) <b>2 YRS</b>	IF UNDER 1 YEAR <b>2 MONTHS</b>	IF UNDER 24 HRS <b>0 DAYS HOURS MIN</b>
7a BIRTHPLACE (State or foreign country) <b>Md.</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH <b>Prince George's</b>	Md.	
10 CITY OR TOWN OF DEATH <b>Cheverly</b>		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Prince Geo. Gen'l Hospital</b>	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY	
13a. U.S.A. RESIDENCE (Where deceased lived, if institution: Reside before admission) STATE <b>Maryland</b>		13c. CITY OR TOWN <b>Prince George's</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER <b>6309 St. Barnbas Rd.</b>	
14. FATHER'S NAME <b>Sidney</b>	Middle <b>Joseph Proctor</b>	15. MOTHER'S MAIDEN NAME <b>Mary</b>	Middle <b>Louise</b>	Last <b>Simms</b>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown?	16b. SOCIAL SECURITY NO	17 INFORMANT	Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <b>Cardiac Arrest.</b>  7769 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.  (b) <b>Atelectasis of Lungs.</b> DUE TO, OR AS A CONSEQUENCE OF  (c) <b>Pulmonary Edema.</b> DUE TO, OR AS A CONSEQUENCE OF  APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)					
MEDICAL CERTIFICATION		19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>Yes</b>
		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)	
		21d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No	City or Town County State
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>Nov. 21, 1968</b> , to <b>Nov. 24, 1968</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>Nov. 24, 1968</b> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above <input checked="" type="checkbox"/> (we) did <input checked="" type="checkbox"/> (did not) view the body after death.					
22b. SIGNATURE <i>Bernardo Alvarado, M.D.</i>					
22c. DATE SIGNED <b>Nov. 25, 1968</b>					
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS <b>Prince Geo. Gen'l Hospital, Cheverly, MD.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <b>11/27/68</b>	23c. NAME OF CEMETERY OR CREMATORIUM <b>St. Paul Methodist</b>	23d. LOCATION (City or Town) <b>Oxon Hill, Md.</b>	(County) (State)
24. FUNERAL DIRECTOR		ROBERT G. MASON FUNERAL HOME, INC. 2500 NICHOLS AVENUE, S.E. WASH., D.C.	ADDRESS	25a. REC'D BY REGISTRAR DATE <b>DEC 2 1968</b>	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>



**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

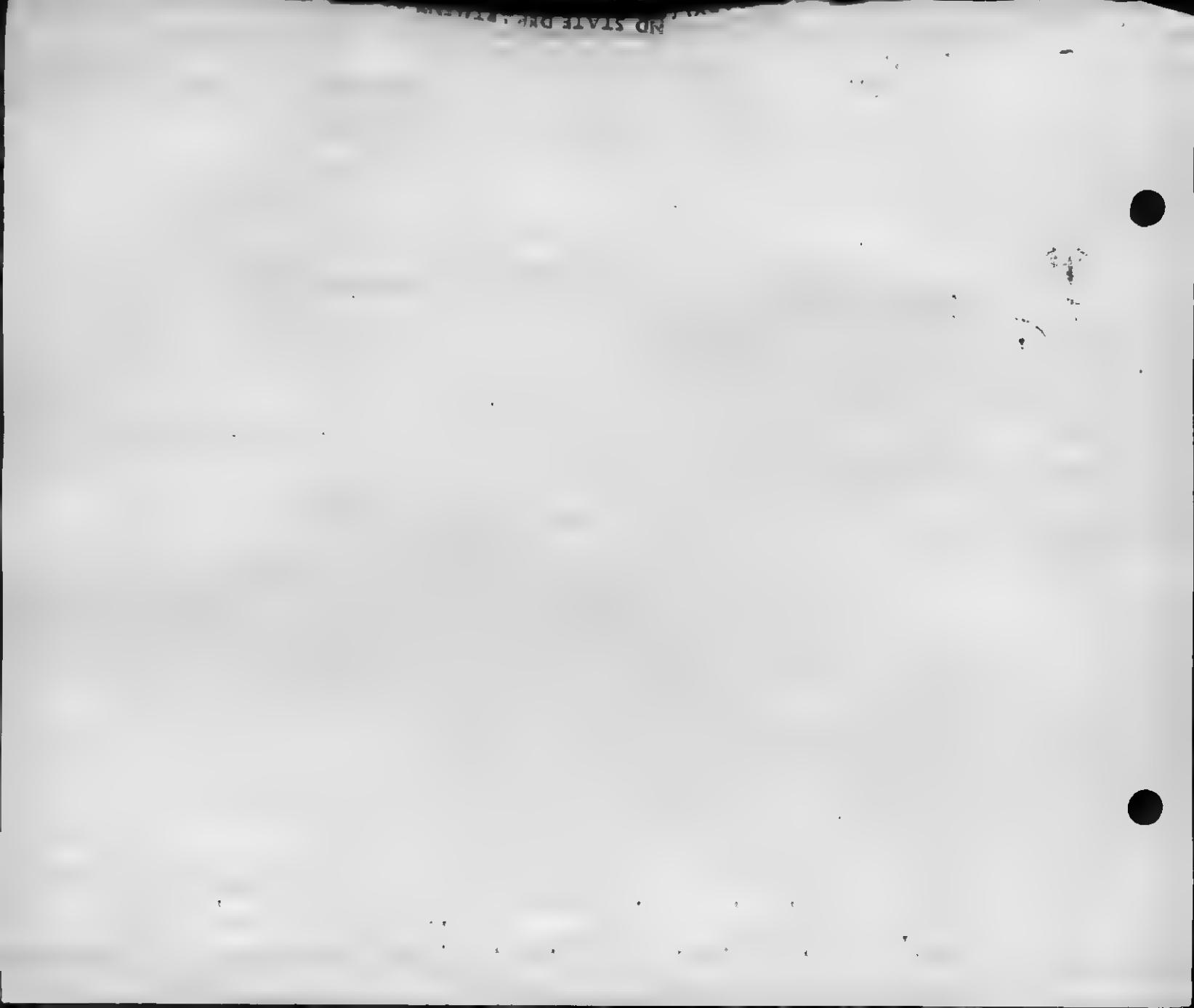
**MARYLAND DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**

**16405**

**CERTIFICATE OF DEATH**

1968

1. PLACE OF DEATH a. COUNTY <i>Prince Georges</i>		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Prince Georges</i>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Riverdale - Temple Hills</i>		c. LENGTH OF STAY IN 1b <i>Always - 77 yrs.</i>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>4708 Temple Hills Road</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Maude Elizabeth PYLES</b>		d. STREET ADDRESS <i>4708 Temple Hills Road</i>	
First	Middle	Last	Month
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>January 23, 1891</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Prince Georges County</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S. of America</b>	
13. FATHER'S NAME <b>Frank H. Small</b>		14. MOTHER'S MAIDEN NAME <b>Annie Norris</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? <b>No</b>		16. SOCIAL SECURITY NO. 17. INFORMANT <b>Son-Carlton Pyles</b> Address <i>4714 Temple Hills Road</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (e), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) <i>Cardiac Failure</i>		INTERVAL BETWEEN ONSET AND DEATH <i>16 minutes</i>	
+1- Conditions, if any, which give rise to immediate cause (a), stating the underlying cause last. (b)		Arteriosclerotic Heart Disease (c)	
		Arteriosclerosis Generalized	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e) <i>Cerebral Thrombosis - Left Hemiplegia</i>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter return of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>March 1961</b> , to <b>November 22, 1968</b> , that (I) (we) last saw the deceased alive on <b>November 21, 1968</b> , and that death occurred at <b>6:15 P.M.</b> from the causes and on the date stated above.		22b. DATE SIGNED <i>November 22, 1968</i>	
22a. SIGNATURE <i>Walcutt W. Gibson</i>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> <i>Walcutt W. Gibson</i> November 22, 1968	
22c. PHYSICIAN'S NAME (Type) <i>Walcutt W. GIBSON</i>		22d. ADDRESS <i>4310 St. Barnabas Road</i>	
23a. BURIAL, CREMATION, 23b. DATE THEREOF REMOVAL (Specify) <b>Burial Nov. 26, 68</b>		23c. NAME OF CEMETERY OR CREMATORIUM <b>St. Barnabas Cemetery</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>Simmons Bros. 1661-Gd. Hope R'. SE. DC.</i>		23d. LOCATION (City, town or county) <b>Oxon Hill, Maryland</b>	
ADDRESS <i>Simmons Bros. 1661-Gd. Hope R'. SE. DC.</i>		25a. REC'D BY REGISTRAR <b>Wash. D.C.</b>	
		25b. REGISTRAR'S SIGNATURE <i>Simmons Bros. 1661-Gd. Hope R'. SE. DC.</i>	
DATE <b>Nov 26 1968</b>		SIGNED <i>Simmons Bros. 1661-Gd. Hope R'. SE. DC.</i>	



**1** **19 HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

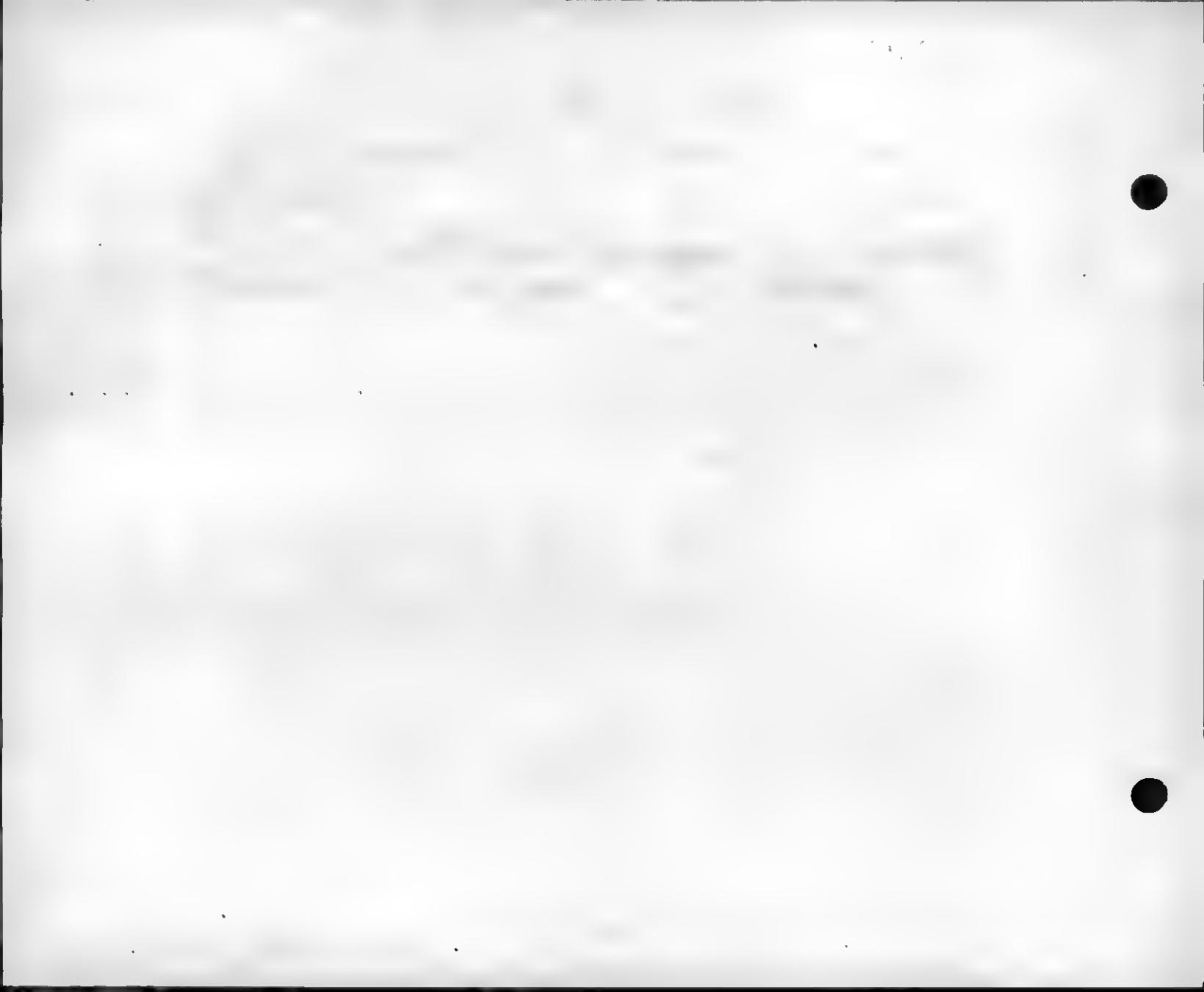
**10 FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

16406 16406

1. DECEASED NAME (Type or print)	First <i>KATHERYN</i>	Middle <i>REA</i>	Last <i>RE</i>	2a. DATE OF DEATH Nov Month 7 Day 19 Year 68	2b. HOUR 10 AM
3. SEX <b>FEMALE</b>	4. RACE <b>White</b>	S. DATE OF BIRTH <b>FEB 22 1879</b>	6. AGE (In years last birthday) <b>89</b> YRS.	IF UNDER 1 YEAR MONTHS GAYS	IF UNDER 24 HRS. HOURS MIN
7a. BIRTHPLACE (State or foreign country) <b>WASH. D.C.</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	9. COUNTY OF DEATH <b>PRINCE GEORGE'S</b>	Md	
10. CITY OR TOWN OF DEATH <b>HYATTSVILLE</b>	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>HYATTSVILLE NURSING HOME</b>	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>GOV't</b>	12b. KIND OF BUSINESS OR INDUSTRY <b>Gov't</b>		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>WASH. D.C.</b>	13c. CITY OR TOWN <b>WASH. D.C.</b>	13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	13e. STREET AND NUMBER <b>3355 16TH ST. N.W.</b>		
14. FATHER'S NAME First <i>John L Rea.</i>	Middle <i></i>	Lost <i></i>	15. MOTHER'S MAIDEN NAME First <i>Mary Jonathan</i>	Middle <i></i>	Last <i></i>
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <input type="checkbox"/>	16b. SOCIAL SECURITY NO. (If yes give war or dates of service)	17. INFORMANT <i>Mrs Grace Thorne, 71, 1501 15th St. N.W.</i>	Address <i>W.D.C.</i>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Bronchopneumonia</i> 470. DUE TO, OR AS A CONSEQUENCE OF <i>Congestive heart failure</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <i>Generalized Visceral Failure</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Senility</i>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>2 days</i> <i>3 months</i> <i>4 months</i> <i>1 year</i>		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>Chronic lymphatic leukemia</i>					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, nat'l by medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (At home, farm, street, factory, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No	City or Town	County	State
22a. I certify that (I) <i>(This hospital)</i> attended the deceased from <i>JAN 1945</i> , to <i>NOV 7, 1968</i> , that (I) <i>(We)</i> last saw the deceased alive on <i>NOV 7, 1968</i> , and that in (my) <i>(our)</i> opinion death occurred on the date and hour and from the causes stated above, (I) <i>(We)</i> <i>(did not)</i> view the body after death.					
22b. SIGNATURE <i>Robert E. Maher MD</i>	DEGREE <i>MD</i>	ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS	22c. DATE SIGNED <i>11-7-68</i>		
22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS <i>1835 Eye St., N.W. Wash. D.C.</i>				
23a. BURIAL, CREMATION REMOVAL (Specify)	23b. DATE <i>11/11/68</i>	23c. NAME OF CEMETERY OR CREMATORIAL <i>Ft. Lincoln Cemetery</i>	23d. LOCATION (City or Town) <i>Prince George's</i>	(County)	(State)
24. FUNERAL DIRECTOR <i>John J. McEntee &amp; Son</i>	ADDRESS <i>31-2 30th Ave N.Y.</i>	25a. REC'D BY REGISTRAR DATE <i>NOV 12 1968</i>	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		



MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

**10 HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

**10 FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as a burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 24 hours after death.

1. DECEASED NAME (Type or print)		First <i>Dorothy</i>	Middle <i>E.</i>	Lost <i>Redmond</i>	2a. DATE OF DEATH Month <i>NOV.</i>	Day <i>WEDNESDAY 3</i>	Year <i>1968</i>	2b. HOUR <i>10 30 A.M.</i>
3. SEX		4 RACE <i>Female</i>	white	S. DATE OF BIRTH <i>DEC 10 1912</i>	6 AGE (in years lost birthday) <i>55 yrs.</i>		IF JUNIOR 1 YEAR MONTHS <i>0</i>	
7a. BIRTHPLACE (State or foreign country) <i>Virginia</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH <i>Prince George's</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>C.S. Govt.</i>	
10 CITY OR TOWN OF DEATH <i>Mt Rainier</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>3716 36th Street</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>Clark</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>C.S. Govt.</i>		
13a. USUA. RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <i>Maryland</i>		13c. CITY OR TOWN <i>Mt Rainier</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER <i>3716 36th Street</i>			
14. FATHER'S NAME First <i>JAMES</i>		Middle <i>E.</i>	Lost <i>Redmond</i>	15. MOTHER'S MAIDEN NAME First <i>Agnes</i>		Middle <i>-</i>	Last <i>McGowen</i>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <i>No</i>		16b. SOCIAL SECURITY NO. <i>579 03 8772</i>		17. INFORMANT <i>Next of kin</i>		Address <i>JAMES E. Redmond 3419 Newton St Mt Rainier Md</i>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Pulmonary emboli</i> 450X DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b), stating the underlying cause (c) DUE TO, OR AS A CONSEQUENCE OF (c) PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>450J</i>								
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>15 minutes</i>								
19a. MEDICAL CERTIFICATION DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.	City or Town	County	State	
22a. I certify that (I) (this hospital) attended the deceased from <i>1957</i> , 19, to <i>Nov 3, 1968</i> , that (I) (we) last saw the deceased alive on <i>Nov 2, 1968</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE <i>Lillian L. Heintzky</i>		DEGREE <i>Attending Phys.</i>	ATTENDING PHYS. <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22c. DATE SIGNED <i>Nov 3, 1968</i>				
22d. PHYSICIAN'S NAME (Type) <i>Lillian Heintzky</i>		22e. ADDRESS <i>Mt Rainier, Md.</i>						
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>11/5/68</i>	23c. NAME OF CEMETERY OR CREMATORIAL <i>Mt Pleasant Cemetery</i>		23d. LOCATION (City or Town) <i>Washington D.C.</i>		(County) (State)	
24. FUNERAL DIRECTOR <i>Miller Funeral Home Mt Rainier, Md.</i>		ADDRESS			25a. REC'D BY REGISTRAR DATE <i>NOV 6 1968</i>	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		



MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

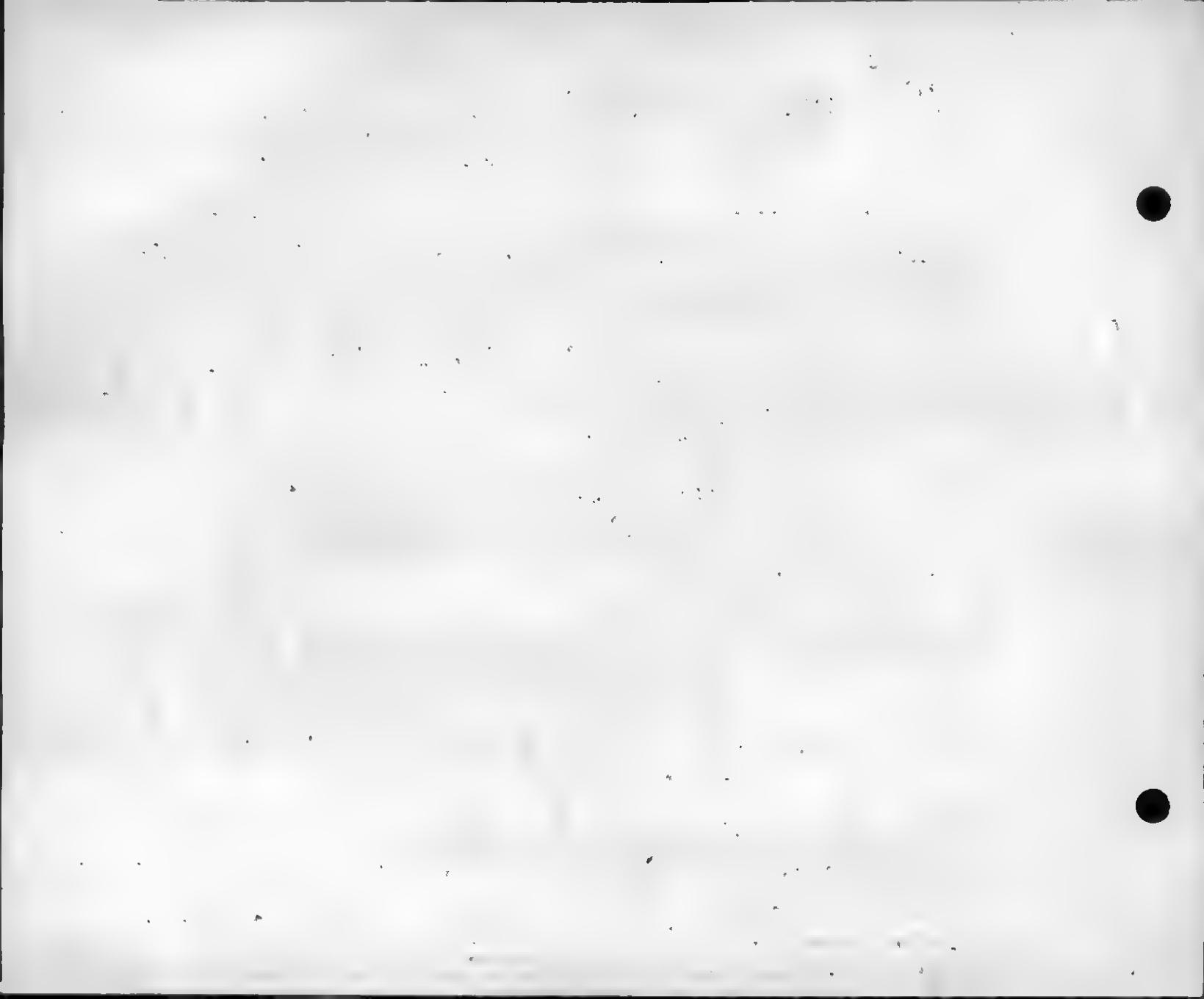
1642.

16408

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

**Page 4 may be retained by the hospital or attending physician.**  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, and file this certificate with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours of death.

1 DECEASED NAME (Type or print)		First <i>Otto</i>	Middle <i>Victor</i>	Last <i>Reeser</i>	2a DATE OF DEATH Month <i>Nov.</i>	Day <i>25</i>	Year <i>1968</i>	26 HOUR <i>3:30PM</i>		
3. SEX <i>Male</i>		4 RACE <i>White</i>		S DATE OF BIRTH <i>1887</i>	6 AGE (In years less birthday) <i>80</i>	IF UNDER 1 YEAR MONTHS <i>YRS</i>		IF UNDER 24 HRS HOURS <i>MIN</i>		
7a BIRTHPLACE (State or foreign country) <i>Penna.</i>		7b CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	9. COUNTY OF DEATH <i>Prince Georges</i>			Md		
10 CITY OR TOWN OF DEATH <i>Hyattsville</i>		11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) <i>Hyattsville Nursing Home</i>		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>Architect</i>			12b KIND OF BUSINESS OR INDUSTRY <i>Building</i>			
13a U.S.A. RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Md.</i>		13c CITY OR TOWN <i>Rockville</i>		13d INSIDE CITY LIMITS? <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e STREET AND NUMBER <i>14366 Chesterfield Road</i>					
14. FATHER'S NAME First <i>Otto</i>		Middle <i>Reeser</i>	Last	15. MOTHER'S MAIDEN NAME First <i>Pauline</i>			Middle	Last		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? <i>No</i>		16b SOCIAL SECURITY NO <i>578-46-7966</i>		17 INFORMANT <i>14366 Chesterfield Rd.</i>			Address <i>Rockville, Md.</i>			
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>4369</i>		DUE TO, OR AS A CONSEQUENCE OF (b) <i>Cerebral Vascular Accidents reported</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>minutes</i>						
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i>337X</i>		DUE TO, OR AS A CONSEQUENCE OF (c) <i>Venousized arteriosclerosis</i>					<i>months</i>			
							<i>years</i>			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>Diseases mellitus</i>										
MEDICAL CERTIFICATION		19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
						<input type="checkbox"/> YES	<input type="checkbox"/> NO			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b.)						
21d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.			City or Town	County	State	
22a. I certify that <input type="checkbox"/> (the hospital) attended the deceased from <i>January</i> , 19 <i>66</i> , to <i>December 25, 1968</i> , that <input type="checkbox"/> (I) (We) last saw the deceased alive on <i>11/19/1968</i> , and that in <input type="checkbox"/> (my) <input type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input type="checkbox"/> (I) <input type="checkbox"/> (We) did not view the body after death.										
22b. SIGNATURE <i>Harold W. Draper M.D.</i>		22c. DEGREE <i>M.D.</i>		ATTENDING PHYS	<input checked="" type="checkbox"/>	MED. DIRECTOR	<input type="checkbox"/>	STAFF PHYS.	<input type="checkbox"/>	DATE SIGNED <i>26 November 1968</i>
22d. PHYSICIAN'S NAME (Type) <i>HAROLD W. DRAPER</i>		22e. ADDRESS <i>9801 Georgia Ave. Silver Spring</i>								
23a. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>11-29-1968</i>		23c. NAME OF CEMETERY OR CREMATORIAL <i>Rock Creek Cemetery</i>			23d. LOCATION (City or Town) <i>Washington, D. C.</i>		(County)  (State)	
24. FUNERAL DIRECTOR <i>John Carter</i> , ADDRESS <i>Sil. Spr. Md.</i> <i>Warren E. Pumphrey, Inc. 8434 Georgia Avenue</i>							25a. REC'D BY REGISTRAR <i>DEC 3 1968</i>	25b. REGISTRAR'S SIGNATURE <i>James J. Jones</i>		



FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1642

1. DECEASED NAME (Type or Print)			First	Middle	Last	2a DATE KNOWN OF DEATH MATEO	Month	Day	Year	2b HOUR	
Edward				M	Ries	5	11	2-68	1970	00pm	
3 SEX	4 RACE	5. DATE OF BIRTH	6. AGE (in years last birthday)	IF UNDER 1 YEAR MONTHS	IF UNDER 24 HRS HOURS						
Male	White	9-8-1892	76 yrs								
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?	8 MARRIED WIDOWED	NEVER MARRIED DIVORCED	9 COUNTY OF DEATH	2c DATE PRONOUNCED DEAD Month Day Year					
Maryland		U.S.A.			Prince George's	11	6	68 19	10	45pm	
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not a hospital give street address)			12a. USAL OCCUPAT ON (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY		
Cheverly			Prince George Hospital			Retired Baker			Md		
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE			13c CITY OR TOWN			13d. INSIDE CITY LIMITS?			13e STREET AND NUMBER		
Maryland			Prince George's Mt. Rainier			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			3731 Wells Avenue		
14 FATHER'S NAME			First	Middle	Last	15. MOTHER'S MAIDEN NAME			First	Middle	Last
Unknown						Unknown					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS (above address)		
Yes			578-09-6769			Edward M. Ries Jr					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY			Heart failure			(Son)			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Minutes		
IMMEDIATE CAUSE (a)			DUE TO, OR AS A CONSEQUENCE OF Arteriosclerotic heart disease						unknown		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			(b)								
			DUE TO, OR AS A CONSEQUENCE OF								
			(c)								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
4200			19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20 AUTOPSY?		
19c. MEDICAL CERTIFICATION									YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19			21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f LOCATION Street or R.F.D. No			City or Town	County	State
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE			John Kehoe			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22b. DATE SIGNED		
EXAMINER'S NAME (Type)			John Kehoe MD Riverdale, Md.			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			11-7-68		
23a. BURIAL, CREMATION REMOVAL (Specify)			23b. DATE 11/11/68			23c. NAME OF CEMETERY OR CREMATORIUM Baltimore Nat. Cem.			23d. LOCATION (City or Town) Baltimore, Md.		
24. FUNERAL DIRECTOR			Nalley's Funeral Inc.,			ADDRESS Mt. Rainier Maryland			24a. REC'D BY REG STRAR DATE 'NOV 14 1968	25b. REGISTRAR'S SIGNATURE Charles Judge	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in Part 1, Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with farm PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

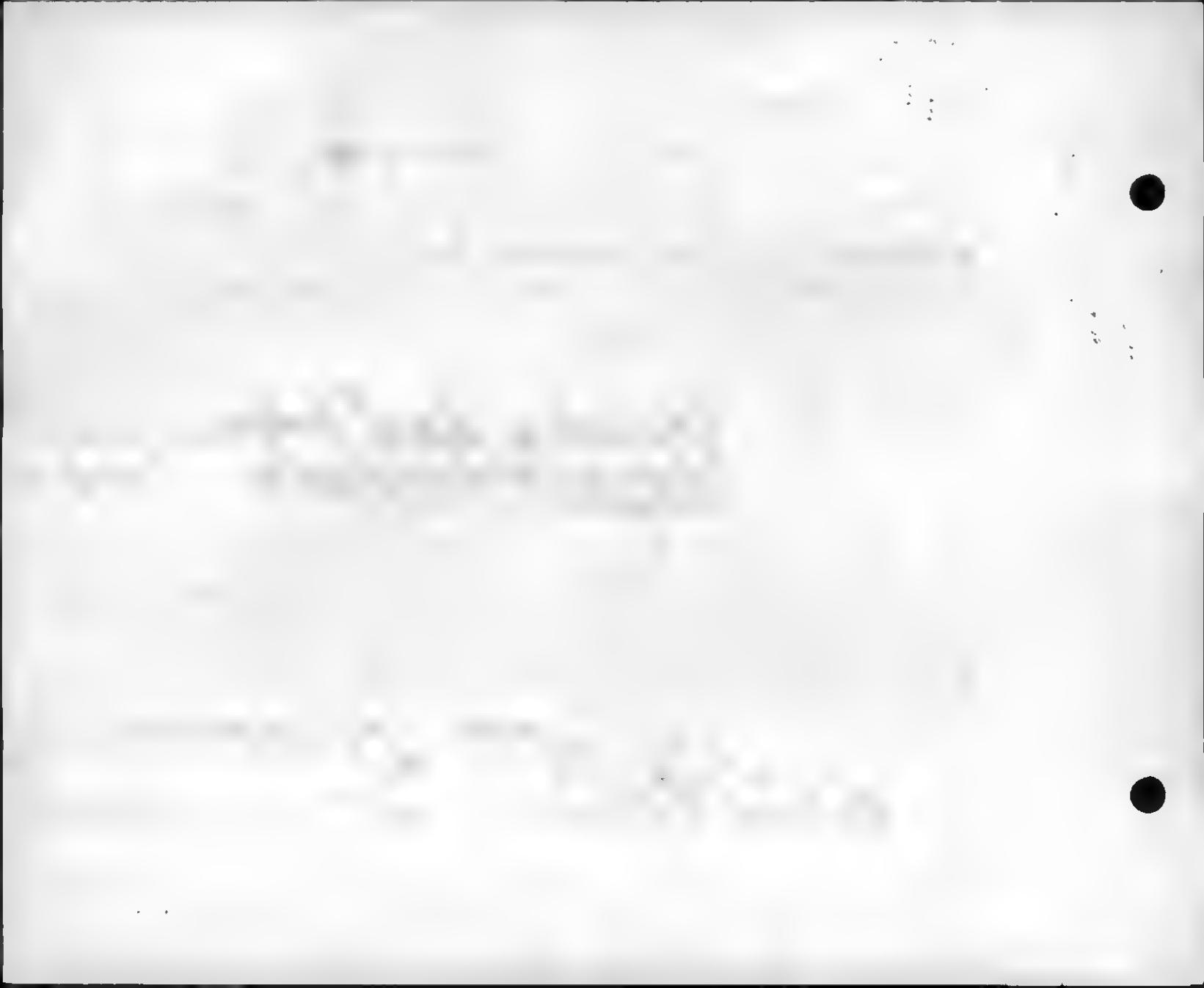
**HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.  
**Page 4 may be retained by the hospital or attending physician.**

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

16410

16421

1. DECEASED NAME (Type or print)		First <i>Charles</i>	Middle <i>L.</i>	Last <i>Roberts</i>	2a. DATE OF DEATH Month <i>Nov.</i>	Day <i>25</i>	Year <i>1968</i>	2b. HOUR <i>9:00 A.M.</i>		
3. SEX <i>Male</i>		4. RACE <i>White</i>		S. DATE OF BIRTH <i>April 4, 1892</i>	6. AGE (in years last birthday) <i>76 yrs.</i>		7. IF UNDER 1 YEAR MONTHS <i>0</i>		8. IF UNDER 24 HRS. HOURS <i>0</i>	
7a. BIRTHPLACE (State or foreign country) <i>Georgia</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH <i>Prince George's</i>		Md.			
10. CITY OR TOWN OF DEATH <i>Hyattsville</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Hyattsville Nursing Home</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY				
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <i>Wash.-D.C.</i>		13b. COUNTY <i>WASH. D.C.</i>		13d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		13e. STREET AND NUMBER <i>1022 TAUSSIG PL N.E.</i>				
14. FATHER'S NAME First <i>Gloste</i>		Middle <i>J.</i>	Last <i>Roberts</i>	15. MOTHER'S MAIDEN NAME First <i>Lula</i>		Middle		Last <i>Richards</i>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? <i>Yes</i>		16b. SOCIAL SECURITY NO. <i>WWI</i>		17. INFORMANT <i>Raymond Vernon</i>		Address				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)  Conditions, if any, wh ch gave rise to immediate cause (a), stating the underlying cause lost.		Congestive heart failure Chronic bronchitis Chronic arteriosclerosis		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>7 days</i>		15 months				
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)  <i>4424</i>										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (At HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No	City or Town		County	State		
22a. I certify that (I) (this hospital) attended the deceased from <i>11/16/68</i> , to <i>11/27/68</i> , to <i>1968</i> , that (I) (we) last saw the deceased alive on <i>11/27/68</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) <input checked="" type="checkbox"/> (did) (did not) view the body after death.										
22b. SIGNATURE <i>Robert Charles</i>		DEGREE ATTENDING PHYS	<input checked="" type="checkbox"/> MED DIRECTOR	<input type="checkbox"/> STAFF PHYS	22c. DATE SIGNED <i>11-25-68</i>					
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS								
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>11/27/68</i>		23c. NAME OF CEMETERY OR CREMATORIUM <i>Glenwood Cemetery</i>		23d. LOCATION (City or Town) (County) (State) <i>Washington, D.C.</i>				
24. FUNERAL DIRECTOR <i>Lee Funeral Home</i>		ADDRESS <i>Washington, D.C.</i>		25a. REC'D BY REGISTRAR <i>DEC 3 1968</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>				



MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

1643.

CERTIFICATE OF DEATH

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print)		First <b>Aubrey</b>	Middle <b>G.</b>	Last <b>Robey</b>	2a. DATE OF DEATH Month <b>Nov.</b>	Day <b>28</b>	Year <b>1968</b>	2b. HOUR <b>5 P.M.</b>				
3. SEX <b>Male</b>		4 RACE <b>White</b>		S. DATE OF BIRTH <b>June 1st, 1910</b>	6 AGE (in years lost birthday) <b>58 yrs</b>		IF UNDER 1 YEAR MONTHS <b>0</b>		IF UNDER 24 HRS HOURS <b>0</b>		MIN. <b>0</b>	
7a. BIRTHPLACE (State or foreign country) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/>	DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH <b>Pr. Geo's</b>		Md.			
10 CITY OR TOWN OF DEATH <b>Forestville</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>3813- 81st. Ave.</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Retired</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>US. Gov.</b>						
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <b>Maryland</b>		13c. CITY OR TOWN <b>Pr. Geo's Forestville</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <b>3813- 81st Ave. SE</b>						
14. FATHER'S NAME First <b>John A. Robey</b>		Middle <b></b>	Last <b></b>	15. MOTHER'S MAIDEN NAME First <b>Mary Garner</b>		Middle <b></b>	Last <b></b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b. SOCIAL SECURITY NO.		17. INFORMANT <b>Edna M. Robey (Wife)</b>		Address <b>Same as # 10</b>						
<p>18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)</p> <p>PART I. DEATH WAS CAUSED BY.</p> <p>IMMEDIATE CAUSE (a) <i>Myocardial Infarction</i></p> <p>DOUE TO, OR AS A CONSEQUENCE OF</p> <p>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) <i>Coronary arteriosclerosis</i></p> <p>DOUE TO, OR AS A CONSEQUENCE OF</p> <p>(c) <i>Hypertension cardiac disease</i></p>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>1 day</i>				
<p>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)</p> <p><i>420i</i></p>								<i>to years</i>				
MEDICAL CERTIFICATION		19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
		21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State								
<p>22a. I certify that (I) (this hospital) attended the deceased from <b>Mar. 5, 1968</b>, to <b>Nov. 28, 1968</b>, that (I) (we) last saw the deceased alive on <b>Oct. 14, 1968</b>, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.</p>								22c. DATE SIGNED <b>Nov. 28, 68</b>				
22b. SIGNATURE <i>Henry G. Hadley</i>		DEGREE ATTENDING PHYS.		MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS <input type="checkbox"/>								
22d. PHYSICIAN'S NAME (Type) <b>Henry G. Hadley</b>		22e. ADDRESS <b>4601 Nichols Ave., S.W., Wash. D.C.</b>										
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>Dec. 2-1968</b>		23c. NAME OF CEMETERY OR CREMATORIAL <b>Cedar Hill Cemetery</b>		23d. LOCATION (City or Town) <b>Suitland, Maryland</b>		(County) <b></b>		(State) <b></b>		
24. FUNERAL DIRECTOR <i>Simmons Bros.</i>		ADDRESS <b>1661-Gd. Hope Rd. SE. Wash. DC</b>		25a. REC'D BY REGISTRAR <b>DEC 3 1968</b>		25b. REGISTRAR'S SIGNATURE <i>Henry G. Hadley</i>						



MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

16412

16420

**10 HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.  
 Page 4 may be retained by the hospital or attending physician.

**10 FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 DECEASED NAME (Type or print)		First	Middle	Last	2d. DATE OF DEATH NOV	Month 6	Day 68	Year 10 A.M.	2b. HOUR 10 A.M.
WINNIE FAY ROGERS									
3. SEX <b>FEMALE</b>		4. RACE <b>CAUC</b>		5. DATE OF BIRTH <b>6 June 1927</b>		6. AGE (In years last birthday) <b>41</b>		IF UNDER 1 YEAR MONTHS <b>YRS</b>	
7a. BIRTHPLACE (State or foreign country) <b>N. CAROLINA</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>PRINCE GEORGE'S</b>		IF UNDER 24 HRS. MONTHS <b>YRS</b>	
10 CITY OR TOWN OF DEATH <b>ANDREWS AFB</b>		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital <b>Malcolm Grow USAFHosp</b> )		12a. USUAL OCCUPATION (Kind of work done during day, even if retired.) <b>HOUSEWIFE</b>		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution Res dence before admission) <b>MD. PRINCE GEORGE</b>		13c. CITY OR TOWN <b>HILLCREST HGSS</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>5951 23RD PARKWAY</b>			
14. FATHER'S NAME First <b>FINLEY</b>		Middle <b>MAINER</b>		15. MOTHER'S MAIDEN NAME First Louise		Middle		Last <b>DAVIS</b>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <b>NO</b>		16b. SOCIAL SECURITY NO. <b>UNK</b>		17 INFORMANT <b>CHARLES R ROGERS</b>		Address <b>SAME AS #13</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Cardiac Arrest</i>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>20 MIN</b>	
<i>4d 1 d</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		DUE TO, OR AS A CONSEQUENCE OF (b) <i>Hypotension</i>		DUE TO, OR AS A CONSEQUENCE OF (c) <i>Urinary</i>				<b>1 DAY</b>	
433. PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>433.1</b>									
20. MEDICAL CERTIFICATION		19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20c. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20d. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>NO</b>	
21a. ACCIDENT WAS UNDERLYING □ OR CONTRIBUTING □ CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No		City or Town		County State	
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>6 Nov 68</b> , to <b>6 Nov 68</b> , that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on <b>6 Nov 68</b> 19 <b>68</b> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) <input type="checkbox"/> (did not) view the body after death.									
22b. SIGNATURE <i>Leonard Farber</i>		DEGREE ATTENDING PHYS		<input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS		22c. DATE SIGNED <b>6 Nov 68</b>			
22d. PHYSICIAN'S <b>LEONARD FARBER, CAPT USAF MC</b>		22e. ADDRESS <b>MALCOLM GROW USAFHOSP ANDREWS AFB</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE <b>Nov. 11, 1968</b>		23c. NAME OF CEMETERY OR CREMATORIUM <b>Cedar Hill Cemetery</b>		23d. LOCATION (City or Town) <b>Portland, Maryland</b>		(County) (State)	
24. FUNERAL DIRECTOR <b>W. W. CHAMBERS CO. 511 11th ST., SE, DC</b>		ADDRESS <b>Wash. D.C.</b>		25a. REC'D BY REGISTRAR <b>NOV 12 1968</b>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		DATE	



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## **CERTIFICATE OF DEATH**

16426

**HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

**10 FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours of death.

1. DECEASED-NAME (Type or print)	First MIDDLE Last			2a. DATE OF DEATH Month Day Year	2b. HOUR	
AGNES			ROLAND			11 25 68 4:18 P.M.
3. SEX <b>Female</b>	4 RACE <b>white</b>	S. DATE OF BIRTH <b>1/22/1876</b>	6. AGE (in years last b'nday) <b>93 yrs</b>	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN		
7a. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9 COUNTY OF DEATH <b>PRINCE GEORGE</b>			
10. CITY OR TOWN OF DEATH <b>Oxon Hill, MD</b>	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Pine View GARDENS</b>	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)	12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) STATE <b>MD.</b>	13c. CITY OR TOWN <b>PRINCE GEORGE</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER			
14. FATHER'S NAME First <b>William</b>	Middle <b>SHORNE</b>	Last <b>AGNES</b>	Middle <b>Bell</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <b>No</b>	16b. SOCIA. SECUR. NO. <b>577-68-7769</b>	17. INFORMANT <b>ARTHUR TAYLOR, Oxon Hill, MD.</b>	Address	APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Circulatory Collapse</b>	DEU TO, OR AS A CONSEQUENCE OF (b) <b>Pneumonia + Malignant cystic bladder</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Cyst of bladder</b>					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) <b>None</b>						
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) los saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death						
22b. SIGNATURE <b>Alfred R. Labin, MD</b>	DEGREE	ATTENDING PHYS	<input checked="" type="checkbox"/> MED DIRECTOR	<input type="checkbox"/> STAFF PHYS	22c. DATE SIGNED <b>11-25-68</b>	
22d. PHYSICIAN'S NAME (Type) <b>ALFRED R. LABIN, MD</b>	22e. ADDRESS <b>Clinton, MD.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>11-27-68</b>	23c. NAME OF CEMETERY OR CREMATORIAL <b>PROVIDENCE CEMETERY</b>	23d. LOCATION (City or Town) <b>Friendly, P.G., MD.</b>	(County)	(State)	
24. FUNERAL DIRECTOR <b>Alfred R. Labin, MD</b>	ADDRESS <b>Hunt Funeral Home, Waldorf, MD.</b>	25a. REC'D BY REGISTRAR DATE <b>NOV 29 1968</b>	25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			



FOR STATE  
HEALTH DEPT.

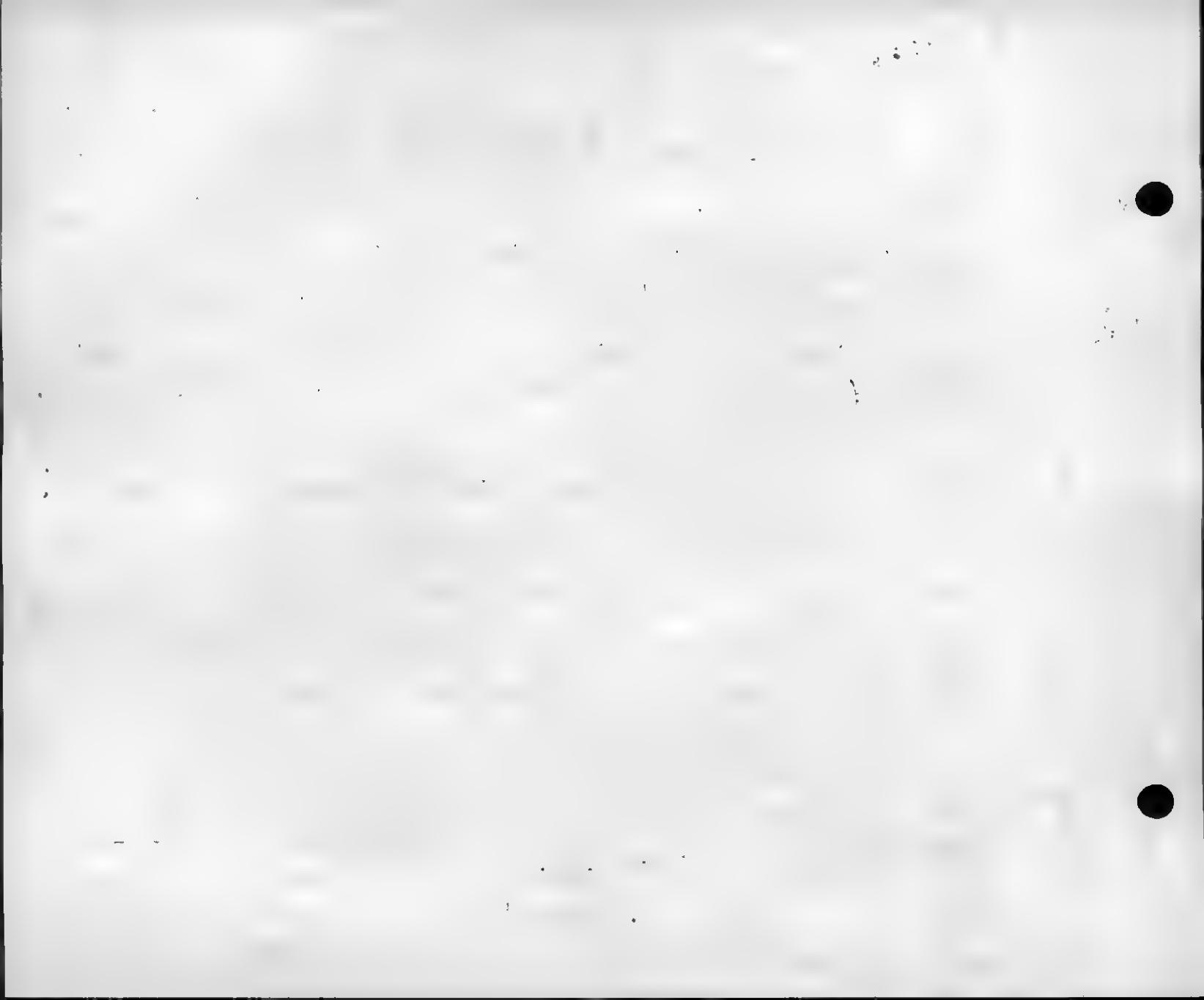
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2 and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner Office along with Farm P.W. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial/transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 DECEASED NAME (Type or Print)			First	Middle	Last	2a. DATE KNOWN OF EST. DEATH MATED <input checked="" type="checkbox"/>	Month	Day	Year	2b HOUR				
Martin			A	Rooney		11-12-68	12	30am						
3 SEX	4. RACE	S. DATE OF BIRTH	6 AGE (in years last birthday)	7 IF UNDER 1 YEAR MONTHS	IF UNDER 24 HRS HOURS									
Male	White	10-25-1896	72 yrs											
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9 COUNTY OF DEATH								
FROSTBURG, MARYLAND		U.S.A.				Prince George's								
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY					
Cheverly			Prince George Hospital			Gov't. worker			Air F. Base					
13a. RESIDENCE (Where deceased lived, if institution)			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?			13e. STREET AND NUMBER					
Maryland			Prince George's Coral Hills			YES <input type="checkbox"/> NO <input type="checkbox"/>			5305 Q Street					
14. FATHER'S NAME			First	Middle	Last	15. MOTHER'S MAIDEN NAME			First	Middle	Last			
Michael					Rooney	Ellen					Barry			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO. (If yes give year or dates of service)			17. INFORMANT			Frostburg, Md.					
No			N.A.			577-12-1717 Mrs. Lawrence Barry, 153 S. Water St.								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY:			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
IMMEDIATE CAUSE (a) Heart failure			minutes											
4129 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause			over 1 yr.											
(b) From Arteriosclerotic heart disease			over 1 yr.											
DUE TO, OR AS A CONSEQUENCE OF														
(c)														
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)														
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?									20. AUTOPSY?		
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day Year HOUR A.M. <input type="checkbox"/> P.M. <input type="checkbox"/> 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b.)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No.			City or Town		County	State		
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>												22b. DATE SIGNED		
ACTUAL SIGNATURE <i>John Kehoe</i>			CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ADDRESS (Street, city, town, or county)									11-12-68		
23a. BURIAL/CREMATION, REMOVAL (Specify)			23b. DATE 11/15/68			23c. NAME OF CEMETERY OR CREMATORIAL St. Michael's Cem.			23d. LOCATION (City or Town) Frostburg, Allegany, Md.			(County)	(State)	
Burial														
24. FUNERAL DIRECTOR Marilou M. Sowers, Hafer-Sowers Funeral Home, 60 W. Main, Frostburg			ADDRESS			25a. RECD BY REGISTRAR			25b. REGISTRAR'S SIGNATURE					
						DATE NOV 18 1968								



**1** 10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.  
**10 FUNERAL DIRECTOR:** After this cert. form has been signed by the attending physician, director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

**MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 1642.1**

**CERTIFICATE OF DEATH**

1. DECEASED NAME (Type or print)		First	Middle	Last	2d. DATE OF DEATH Month 15 Day 68 Year	2b. HOUR 5:30 P.M.	
3. SEX		4 RACE	5. DATE OF BIRTH 7/17/89		6. AGE (in years last birthday) 39 yrs.	1f. UNDER 1 YEAR MONTHS DAYS HOURS M.M.	
7a. BIRTHPLACE (State or foreign country) <i>Canada</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Prince Georges</i>		
10. CITY OR TOWN OF DEATH <i>Clinton</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Blue Cross Gardens</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Builder</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>CONSTR.</i>	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>MD.</i>		13b. COUNTY <i>Charles</i>	13c. CITY OR TOWN <i>Waldorf</i>	13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	13e. STREET AND NUMBER <i>Rt 3 Box 593-A</i>		
14. FATHER'S NAME First <i>CLARENCE A. ROWE</i>		Middle	Last	15. MOTHER'S MAIDEN NAME First <i>HAZEL ROWE</i>		Middle	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? <input type="checkbox"/> Yes, no, or unknown <i>NO</i>		16b. SOCIAL SECURITY NO <i>219-22-0862</i>		17. INFORMANT <i>HAZEL ROWE, WALDORF, MD</i>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Cardiovascular Disease</i>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
185X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last		DUE TO, OR AS A CONSEQUENCE OF (b) <i>Ca. of Prostate</i>					
		DUE TO, OR AS A CONSEQUENCE OF (c) <i>Arterio-Myocardial Disease</i>					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>177X</i>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? <input type="checkbox"/> YES <input type="checkbox"/> NO	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>Alfred Ream</i>		DEGREE ATTENDING PHYS	<input type="checkbox"/> MED DIRECTOR	<input type="checkbox"/> STAFF PHYS	22c. DATE SIGNED <i>11-15-68</i>		
22d. PHYSICIAN'S NAME (Type) <i>ALFRED REAM</i>		22e. ADDRESS <i>Bethesda, MD.</i>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>Nov. 19, 1968</i>	23c. NAME OF CEMETERY OR CREMATORIAL <i>CEDAR HILL Cem.</i>		23d. LOCATION (City or Town) <i>SUITLAND</i>	(County) <i>MD.</i>	(State)
24. FUNERAL DIRECTOR <i>Auntie Funeral Home, Waldorf, Md.</i>		ADDRESS <i>ADDRESS</i>	25a. REC'D BY REGISTRAR <i>DATE 20 1968</i>		25b. REGISTRAR'S SIGNATURE <i>reverley Judge</i>		



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death, or any delay is necessary, please execute the certificate, writing the word "pending" on pencil in Item 18. Give pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 5, may be retained for your files.

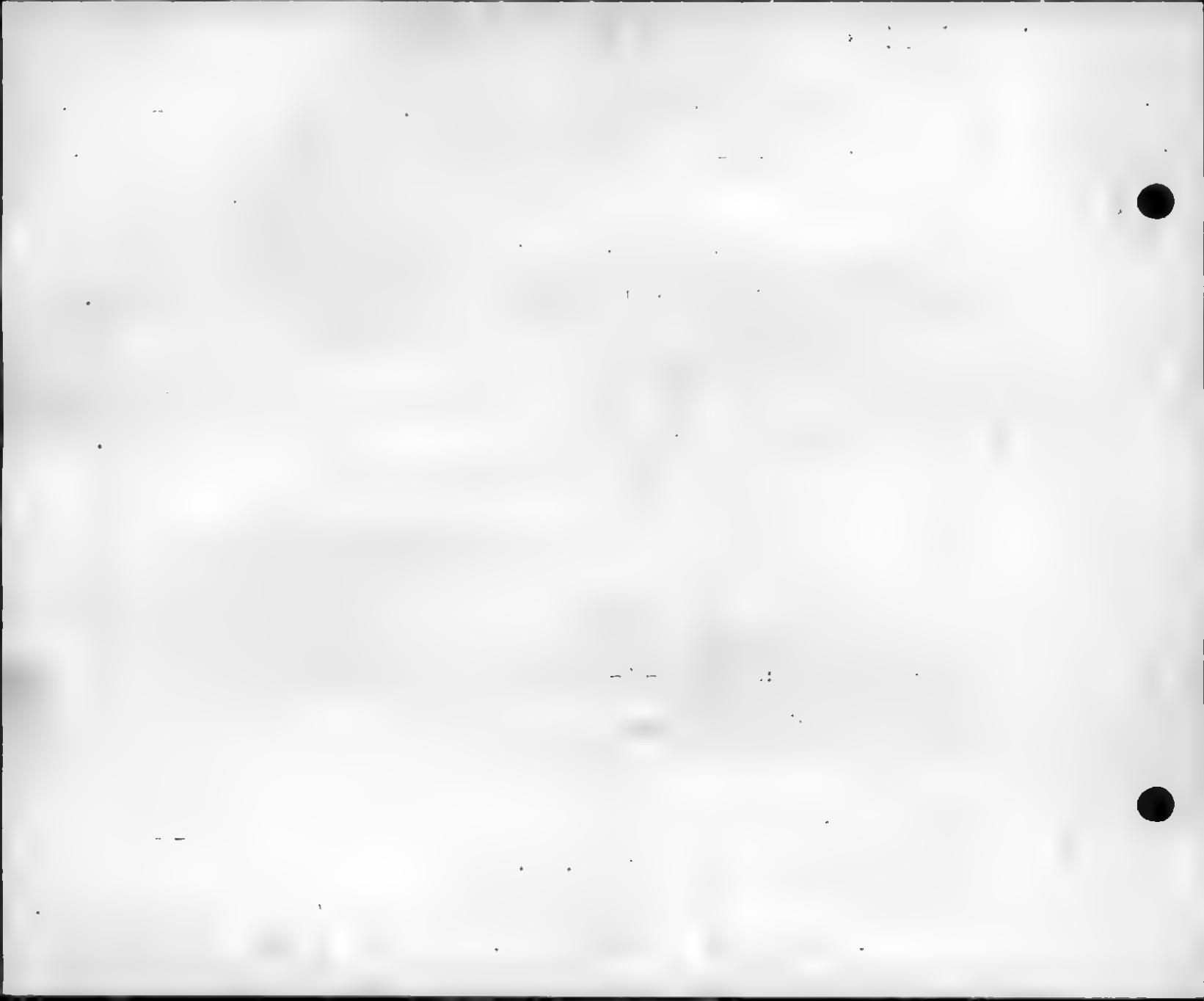
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
16416 DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

164 '11

Item #1, Film #406 11 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 DECEASED NAME (Type or Print)			First	Middle	Last	2a DATE KNOWN OF ESTI- DEATH MATED	Month	Day	Year	2b. HOUR	
Richard Garret Carvie Salter Sr.						<input checked="" type="checkbox"/>	11	4	1968	19 11:30am	
3 SEX	4 RACE	S. DATE OF BIRTH	6 AGE (in years last birthday)	F UNDER 1 YEAR	IF UNDER 24 HRS						
Male	White	3-24-1899	69 YRS	MONTHS	DAYS	HOURS	MIN				
7a. BIRTHPLACE (State or foreign country) N C	7b. CITIZEN OF WHAT COUNTRY? USA	B MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	9 COUNTY OF DEATH Prince George's	2c. DATE PRONOUNCED DEAD Month 4 Year 68	2d. HOUR 11:30am						
7c. WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>											
10 CITY OR TOWN OF DEATH Cheverly			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Prince George Hospital			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Retired welder			12b. KIND OF BUSINESS OR INDUSTRY Railroad co		
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Maryland			13c. CITY OR TOWN Prince George's Seabrook			13d. INS. & DEATH LHMIS? YES <input type="checkbox"/> NO <input type="checkbox"/>			13e. STREET AND NUMBER 9321 Washington Blvd.		
14 FATHER'S NAME First Middle Last			15 MOTHER'S MAIDEN NAME First Middle								
Frank K Salter			Florence Taylor								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes			16b. SOCIAL SECURITY NO 718 14 9687			17. INFORMANT Mildred W Salter			ADDRESS Seabrook, Md.		
PART 1. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac arrest			DUE TO, OR AS A CONSEQUENCE OF Bilateral hemothorax						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH min.		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost			(b) and multiple fractures						8 days		
			DUE TO, OR AS A CONSEQUENCE OF (c)						8 days		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
850 X			19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
MEDICAL CERTIFICATION			21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year HOUR A.M. 8:15 p.m. 10-27-1968			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b.) Run over by car		
			21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) Driveway of home			21f. LOCATION Street or R.F.D. No City or Town County State same as #13		
			22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>						22b. DATE SIGNED 11-5-68		
ACTUAL SIGNATURE <i>John Kehoe</i>						CHIEF MEDICAL EXAMINER <input type="checkbox"/> MD ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ADDRESS (Street, city, town, or county) Colmar Manor Pro Geo Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE Nov 7, 1968			23c. NAME OF CEMETERY OR CREMATORIAL Ft Lincoln Cemetery			23d. LOCATION (City or Town) (County) (State) Colmar Manor Pro Geo Md.		
24. FUNERAL DIRECTOR F. Gasch's Sons Hyattsville, Md.			ADDRESS			25a. REC'D BY REGISTRAR DATE NOV 8 1968			25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		



MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

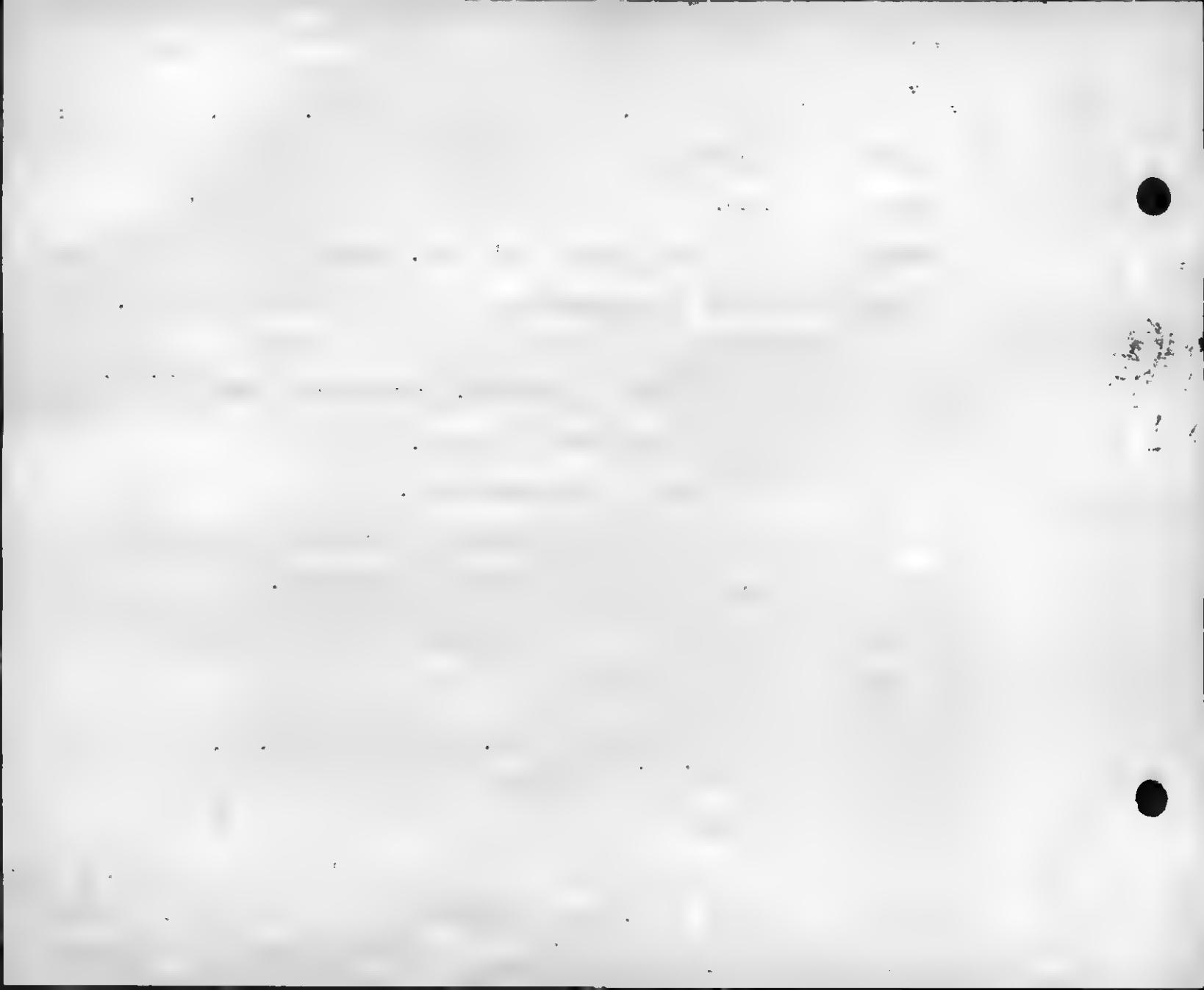
CERTIFICATE OF DEATH

10-43

16417

**10 HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.  
**Page 4** may be retained by the hospital or attending physician.  
**10 FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician, it should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 through 3 should be filed with the State Dept. of Health prior to burial/cremation, or removal, and in any event, within 72 hours after death.

1 DECEASED NAME (Type or print)				First	Middle	Last	2a. DATE OF DEATH Month Day Year	2b. HOUR		
				Vita	D.	Salvia	Nov. 10, 1968	3:50PM		
3. SEX		4 RACE		5. DATE OF BIRTH		6. AGE (In years lost birthday)		IF UNDER 1 YEAR		
Female		Caucasian		11/6/92		76 yrs		MONTHS	IF UNDER 24 HRS	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		9. COUNTY OF DEATH				
Italy		U.S.A.		WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		Prince George's				
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY				
Cheverly		Prince George's Gen'l Hosp. housewife				own home				
13a. USUAL RESIDENCE (Where deceased lived, if institution) STATE		13b. CITY OR TOWN		13c. INSIDE CITY, M.V.T?		13d. STREET AND NUMBER				
Maryland		Prince George's Bladensburg		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		5800 Annapolis Rd.				
14. FATHER'S NAME		First	Middle	Last	15. MOTHER'S Maiden Name		First	Middle	Last	
		Unknown					Unknown			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		16b. SOCIAL SECURITY NO		17. INFORMANT		Address				
		577-62-23179		Frank J. Cucchiara		1106 Osage Street		Sil. Spr., Md.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) <u>Cardiac Arrest (clinical).</u>										
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost <u>519</u>										
(b) <u>Bilateral Bronchopneumonia.</u>										
DUE TO, OR AS A CONSEQUENCE OF										
(c) <u>Atelectasis of lungs, due to bilateral serosanguinous</u>										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
pleural effusions, massive - Coronary Arteriosclerosis.										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		Yes				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No		City or Town	County	State		
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>Nov. 10, 1968</u> , to <u>Nov. 10, 1968</u> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>Nov. 10, 1968</u> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) <input checked="" type="checkbox"/> view the body after death.										
22b. SIGNATURE <u>Arnold G. Brody</u>		DEGREE	ATTENDING PHYS	<input checked="" type="checkbox"/> MED DIRECTOR	<input type="checkbox"/> STAFF PHYS	22c. DATE SIGNED				
22d. PHYSICIAN'S NAME (Type) <u>ARNOLD G. BRODY</u>		22e. ADDRESS		Prince George's General Hospital, Cheverly						
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>11-13-1968</u>		23c. NAME OF CEMETERY OR CREMATORIUM <u>Hausoleum Ft. Lincoln Cemetery</u>		23d. LOCATION (City or Town) (County) <u>Prince Geos. Maryland</u>		Maryland		
24. FUNERAL DIRECTOR <u>Jerry J.W. Lee</u>		ADDRESS <u>Sil. Spr. Md.</u>		25a. RECEIVED BY REGISTRAR <u>NOV 14 1968</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>				



MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16432

16418

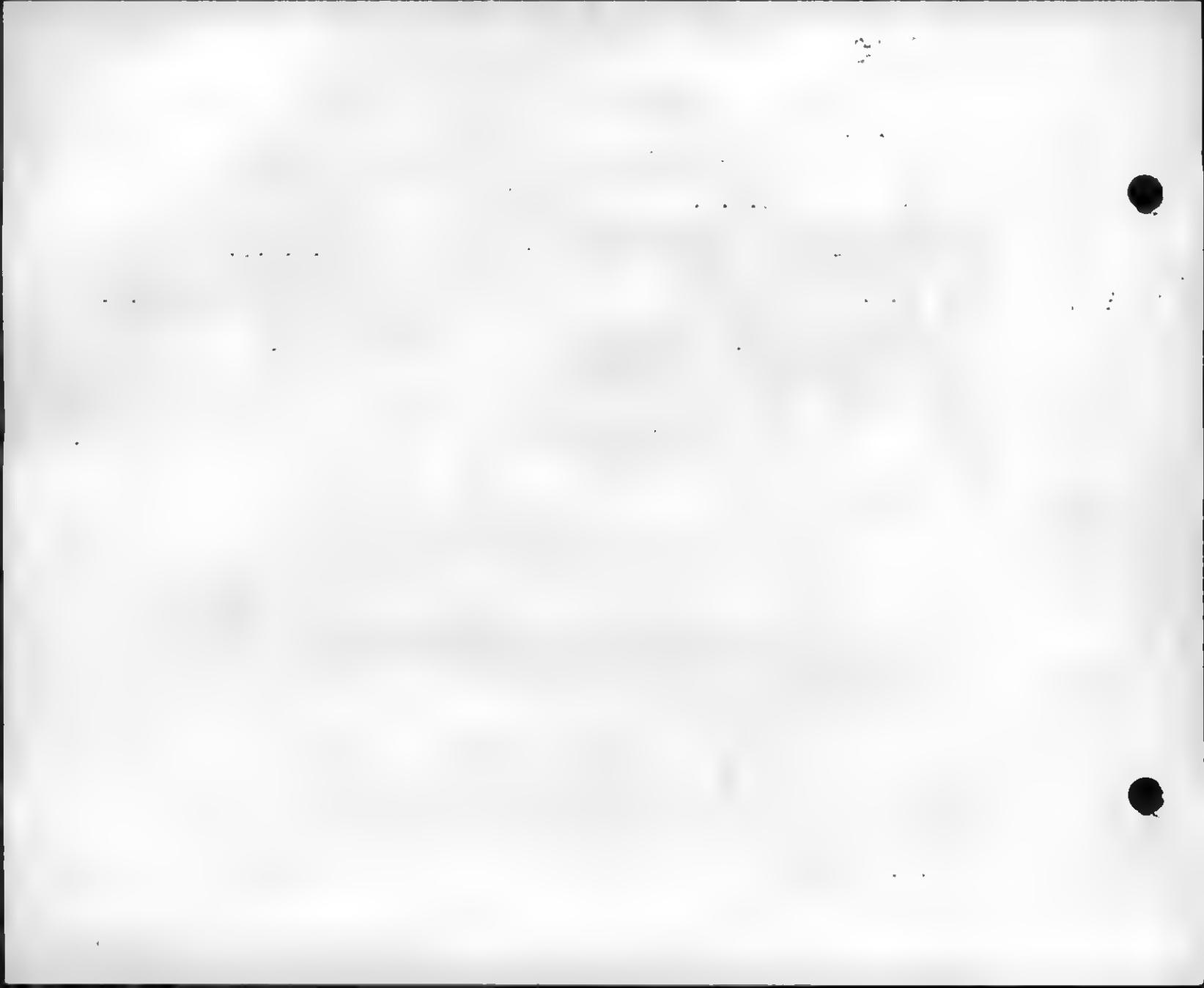
CERTIFICATE OF DEATH

To HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician

To FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Please sign and file this certificate with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death. It should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print)			First <b>JOHN</b>	Middle <b>ALEXANDER</b>	Last <b>SAMFORD</b>	2a. DATE OF DEATH Month <b>NOV</b>	Day <b>20</b>	Year <b>68</b>	2b. HOUR P <b>6:00 M</b>			
3 SEX <b>Male</b>		4 RACE <b>Caucasian</b>	5. DATE OF BIRTH <b>29 Aug 1905</b>			6 AGE (In years last birthday) <b>63</b>		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN		
7a. BIRTHPLACE (State or foreign country) <b>NMEX</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>			9. COUNTY OF DEATH <b>PRINCE GEORGES</b>			Md			
10. CITY OR TOWN OF DEATH <b>ANDREWS AFB</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Malcolm Grow USAF Hosp</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>Gen U.S.A.F.</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>Retired</b>				
13a. USUAL RESIDENCE (Where deceased lived, if institution, Residene before admission) STATE <b>Wash D.C.</b>		13c. CITY OR TOWN <b>V</b>	13d. INSIDE CITY LIMITS? <b>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></b>		13e. STREET AND NUMBER <b>5008 Fulton N.W.</b>							
14 FATHER'S NAME <b>Charles</b>		First <b>M.</b>	Middle <b>Samford</b>	Last	15. MOTHER'S MAIDEN NAME First <b>Adeline</b>		Middle <b>S.</b>	Last				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <b>Yes</b>		16b. SOCIAL SECURITY NO <b>1924-1960 679529222</b>		17 INFORMANT <b>Wife</b>		Address <b>Same as item # 13</b>						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Carcinoma of lung</b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>3 mo.</b>		
1621 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)												
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 163X												
MEDICAL CERTIFICATION		19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>No</b>			
		21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> DR CONTR BTNG <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
MEDICAL CERTIFICATION		21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY OFFICE BUILDING, ETC)		21f. LOCATION Street or R.F.D. No City or Town County State					
		22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>13 Nov</b> , 19 <b>68</b> , to <b>20 Nov</b> , 19 <b>68</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>20 Nov</b> 19 <b>68</b> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) <input checked="" type="checkbox"/> (did not) view the body after death										
MEDICAL CERTIFICATION		22b. SIGNATURE <i>W.F. Burger</i>			DEGREE <b>PHYS</b>	ATTENDING <b>X</b>	MED DIRECTOR <input type="checkbox"/>	STAFF PHYS <input type="checkbox"/>	22c. DATE SIGNED <b>20 Nov 68</b>			
		22d. PHYSICIAN'S NAME (Type) <b>W.F. BURGER, CAPT, USAF, MC</b>			22e. ADDRESS <b>MALCOLM GROW USAF HOSP ANDREWS AFB</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>11-25-68</b>		23c. NAME OF CEMETERY OR CREMATORIAL <b>Arlington National Cemetery</b>			23d. LOCATION (City or Town) (County) (State)					
24. FUNERAL DIRECTOR <b>Paul A. DeVol</b>		ADDRESS <b>De Vol Funeral Home Wash. D.C.</b>		25a. REC'D BY REGISTRAR DATE <b>NOV 29 1968</b>			25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>					

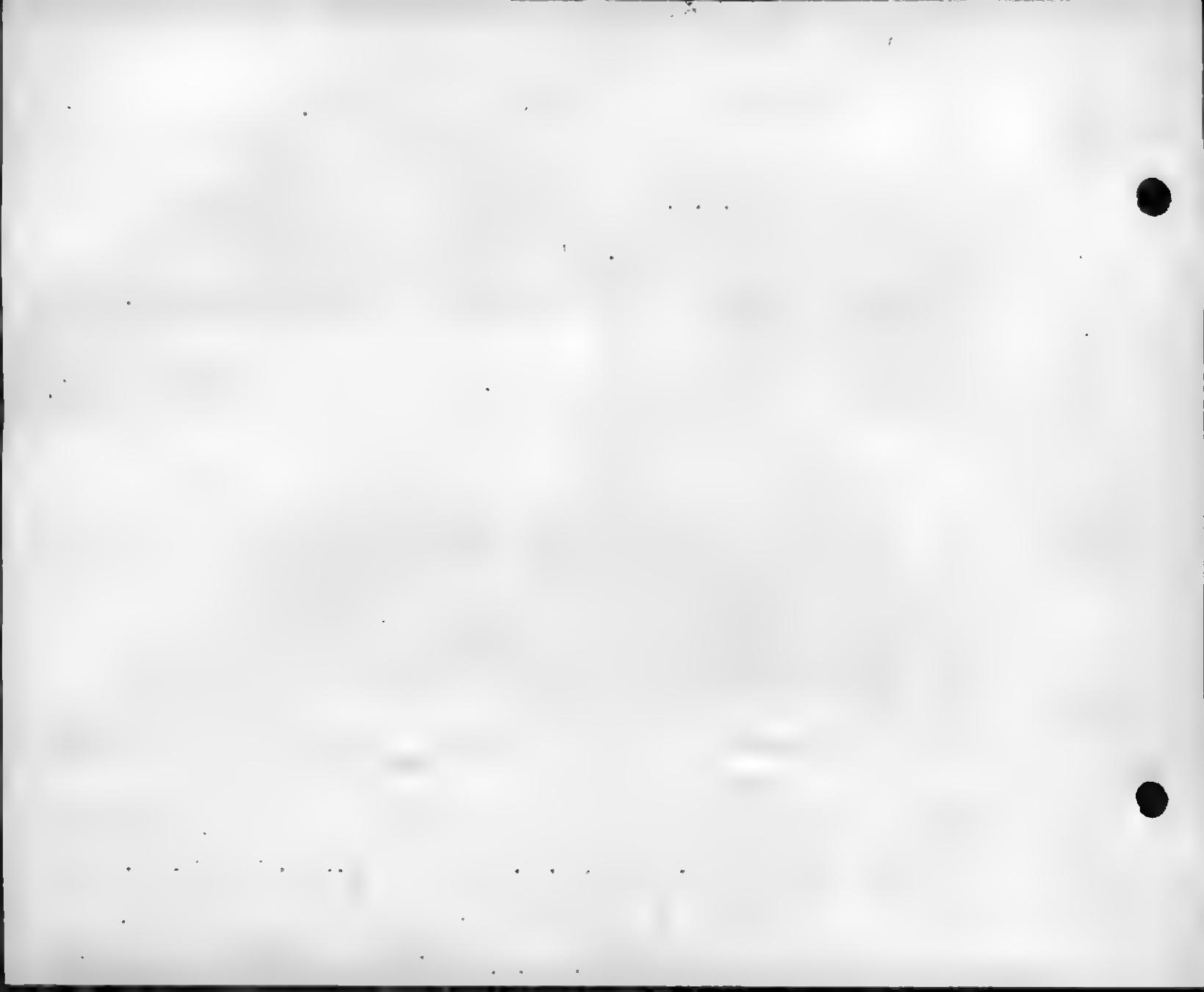


MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
CERTIFICATE OF DEATH

**10 HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.  
**10 FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial permit. Then please remove carbon papers. Please sign and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 DECEASED NAME (Type or print)		First  <b>Samuel</b>	Middle  <b>Schonfeld</b>	Last  <b>Schonfeld</b>	2a DATE OF DEATH Month <b>Nov.</b>	Day <b>5,</b>	Year <b>1968</b>	2b HOUR 9:30A M			
3 SEX  <b>Male</b>		4. RACE  <b>Caucasian</b>		5. DATE OF BIRTH  <b>11/27/83</b>		6. AGE (in years last birthday) <b>84</b>		IF UNDER 1 YEAR MONTHS <b>84</b>	IF UNDER 24 HRS DAYS <b>0</b>	26 HOUR HOURS <b>9</b>	MIN <b>30</b>
7a BIRTHPLACE (State or foreign country) <b>Russia</b>		7b CITIZEN OF WHAT COUNTRY?  <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH  <b>Prince George's</b>		Md			
10 CITY OR TOWN OF DEATH  <b>Cheverly</b>		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)  <b>Prince Geo. Gen'l Hospital</b>		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)  <b>Jeweler</b>		12b KIND OF BUSINESS OR INDUSTRY					
13a USUAL RESIDENCE (Where deceased lived, if institution admission) STATE <b>Maryland</b>		13c CITY OR TOWN  <b>Prince George's</b>		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER  <b>6700 Belcrest Rd.</b>					
14 FATHER'S NAME  <b>Joseph Schonfeld</b>		15 MOTHER'S MAIDEN NAME  <b>Freda --</b>									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown  <b>Yes</b>		16b. SOCIAL SECURITY NO.  <b>4337</b>		17 INFORMANT  <b>Mrs. Dorothy Katz, 6700 Belcrest Rd., W. Hyattsville, Md.</b>							
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)  <b>Cerebro-Vascular Thrombosis</b>								APPENDIX MATE INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b>			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause  <b>lost</b>		DUE TO, OR AS A CONSEQUENCE OF (b)  <b>Cerebro-Vascular Sclerosis</b>									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)  <b>332X Carcinoma Colon</b>											
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)							
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE, BUILDING, ETC.)		21f LOCATION Street or R.F.D. No.		City or Town		County		State	
22a. I certify that <input type="checkbox"/> (this <del>has</del> <del>had</del> ) attended the deceased from <b>Sept. 19, 1968</b> , to <b>Nov. 4, 1968</b> , that <input type="checkbox"/> (s) <del>had</del> last saw the deceased alive on <b>Nov. 4, 1968</b> , and that in my <input type="checkbox"/> <del>my</del> opinion death occurred on the date and hour and from the causes stated above. <input type="checkbox"/> (s) <del>had</del> <input type="checkbox"/> (s) <del>had</del> <input type="checkbox"/> (s) <del>had</del> view the body after death.											
22b. SIGNATURE  <b>Benjamin S. Miller, MD</b>		DEGREE  <b>MD</b>		ATTENDING PHYS. <input checked="" type="checkbox"/>		MED DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>		22c DATE SIGNED  <b>5 Nov 68</b>	
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS  <b>3824 34th St., Mt. Rainier, Md. 20822</b>									
23a BURIAL, CREMATION, REMOVAL (Specify)  <b>Burial</b>		23b DATE  <b>11/7/68</b>		23c NAME OF CEMETERY OR CREMATORIAL  <b>King David Mem. Garden</b>		23d LOCATION (City or Town)  <b>Falls Church, Va.</b>		(County)		(State)	
24 FUNERAL DIRECTOR  <b>Bernard Danzansky &amp; Sons</b>		ADDRESS  <b>3501 14th St. N.W. Wash. D.C. 20001</b>		25a. REG'D. BY REG. STAR  <b>NOV 12 1968</b>		25b. REGISTRAR'S SIGNATURE  <b>Charles Judge</b>					



**1**  
10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.



Items 7 & 8 FilmGu06  
11/12/68 kk

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16420

CERTIFICATE OF DEATH

16434

1 DECEASED NAME (Type or print)	First Mary	Middle C.	Lost Sellman	2a DATE OF DEATH November 1, 1968	2b HOUR 8:45 AM
3. SEX Female	4 RACE Colored	5 DATE OF BIRTH 8/1/13	6 AGE (in years last birthday) 55 YRS.	IF UNDER 1 YEAR MONTHS	IF UNDER 24 HRS HOURS MIN
7a BIRTHPLACE (State or foreign country) Maryland	7b CITIZEN OF WHAT COUNTRY? USA	B. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Prince George's Md		
10 CITY OR TOWN OF DEATH Cheverly	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Prince George's Gen. Hosp.	12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)	12b KIND OF BUSINESS OR INDUSTRY		
13a USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE Maryland	13b CITY OR TOWN Prince Geo. Upper Marlboro	13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e STREET AND NUMBER Box 3919		
14 FATHER'S NAME First	Middle	15 IS MOTHER'S MAIDEN NAME First	Middle	Last	
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown	16b SOCIAL SECURITY NO	17 INFORMANT	Address		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Coma &amp; failure</i> 1570 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) <i>Generalized carcinomatosis</i> DUE TO, OR AS A CONSEQUENCE OF lost (c) <i>Carcinoma of the head of the pancreas</i> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)					
19a MEDICAL CERTIFICATION DATE	19b. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner)	21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b)			
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)	21f LOCATION Street or RFD No. City or Town County State			
22a I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>Oct 26, 1968</u> to <u>Nov. 1, 1968</u> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>Nov. 1, 1968</u> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) (did) <input type="checkbox"/> (did not) view the body after death.					
22b SIGNATURE <i>Mourtzanakis</i>	22c DATE SIGNED 11/3/68	DEGREE ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>			
22d PHYSICIAN'S NAME (Type) E. D. Mourtzanakis, M. D.	22e ADDRESS Prince Georges General Hosp., Cheverly, Md.				
23a BURIAL, CREMAT. ON, REMOVAL (Specify) Burial	23b DATE 11-6-68	23c NAME OF CEMETERY OR CREMATORIUM Lincolen Cemetery	23d LOCATION (City or Town) Glenelg Maryland	(County)	(State)
24 FUNERAL DIRECTOR Collins Funeral Home Inc Washington DC	ADDRESS 4539 - 16th St. N.E.	25a REC'D. BY REGISTRAR NOV 6 1968	25b REGISTRAR'S SIGNATURE Charles Judge		

4  
A  
2  
1

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

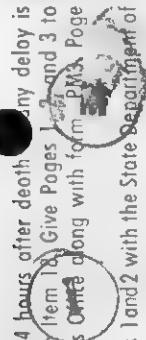
## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Avon Vale		c. LENGTH OF STAY IN lb Yrs	
d. NAME OF HOSPITAL (If not in hospital, give street address) #4 Avon Place		e. STREET ADDRESS #4 Avon Place	
3. NAME OF DECEASED (Type or print) Carrie		First L.	Middle Sentell
4. DATE OF DEATH November 16 1968		Month	Day Year
5. SEX female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/30/1906
9. AGE (In years less than 1 year) 7 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sales Rep		10b. KIND OF BUSINESS OR INDUSTRY Retail	11. BIRTHPLACE (State or foreign country) Nor Ma
12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Francis M. Sentell		14. MOTHER'S MAIDEN NAME Beulah K. Wray	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 57-346873A	17. INFORMANT Mary K. Slocombe Same as above
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]  PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		INTERVAL BETWEEN ONSET AND DEATH 2-3 months	
1538 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b)			
DUE TO  DUE TO (c) Carcinoma of Colon and Breast		6 months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from May 1950, to 11-16 1968, that I last saw the deceased alive on 11-14 1968, and that death occurred at 11:30 AM, from the causes and on the date stated above.		ADDRESS (Street, city or town, state) M.D. 11161 New Hampshire Ave Silver Spring, Md.	
ACTUAL SIGNATURE <i>Robert B. Irey</i>		DATE SIGNED 11/16/68	
PHYSICIAN'S NAME (Type) ROBERT B. IREY			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/19/1968	22c. NAME OF CEMETERY OR CREMATORIAL Buckley Cemetery
22d. LOCATION (City, town, or county) Atlanta, Ga.		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE Wallie's Funeral Home		ADDRESS Mt. Rainier, Md.	24a. REC'D BY REGISTRAR DATE Nov 25 1968
			24b. REGISTRAR'S SIGNATURE <i>J. J. Irey Judge</i>



FOR STATE  
HEALTH DEPT.



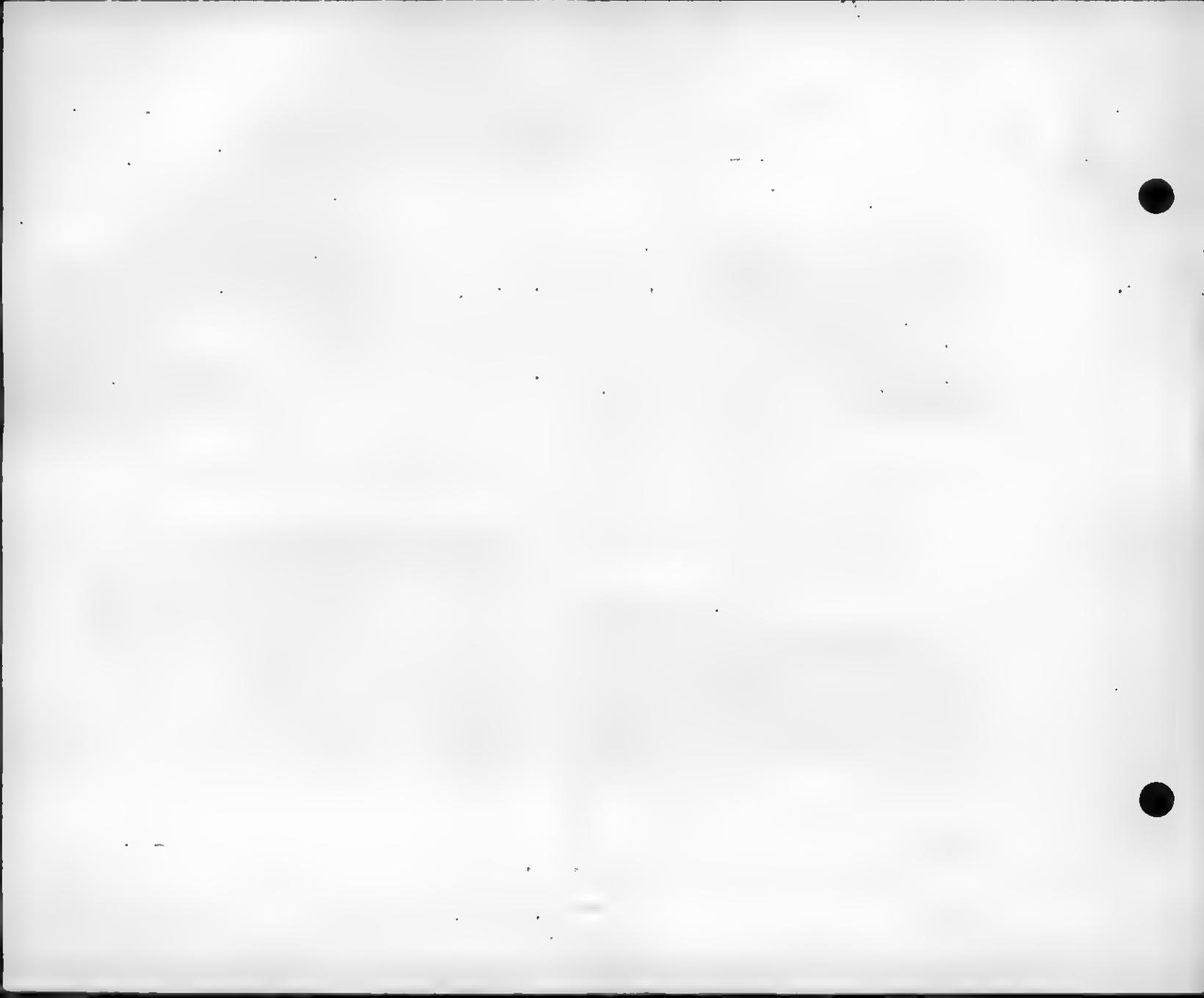
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 1. Give Pages 1 and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or Print)		First	Middle	Last	2a. DATE KNOWN <input type="checkbox"/> Month Day Year	2b. HOUR		
3 SEX	4 RACE	5 DATE OF BIRTH	6. AGE (In years last birthday)	7. IF UNDER 1 YEAR MONTHS      DAYS	8. IF UNDER 24 HRS HOURS      MIN.			
Male	White	8-8-1905	63 YRS					
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		9. COUNTY OF DEATH		
PENNA.		U.S.A.		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		Prince George's		
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY	
Cheverly		Prince George Hospital			MAINTENANCE MAN		MOTEL	
13a. USUAL RESIDENCE (Where deceased lived, if institution admission, STATE		13b. CITY OR TOWN		13d. INSIDE CITY LIMIT?		13e. STREET AND NUMBER		
Maryland		Prince George's		Hyattsville		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> 4705 Oglethorpe Street		
14. FATHER'S NAME		First	Middle	Last	15. MOTHER'S MAIDEN NAME	First	Middle	
UNKNOWN					UNKNOWN			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No or Unknown)		16b. SOCIAL SECURITY NO. (If yes give war or dates of service)		17. INFORMANT		ADDRESS		
UNKNOWN		577-20-6701		ROBERT KIRK		8419 BALTIMORE AVE, COLLEGE PARK MD.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH minutes						
Heart failure 41yrs Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		DUE TO OR AS A CONSEQUENCE OF Arteriosclerotic heart disease over 1 year						
(b) DUE TO, OR AS A CONSEQUENCE OF								
(c)								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M.		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No		City or Town	County	State
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>								
ACTUAL SIGNATURE		CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> ADDRESS (Street, city, town, or county)						22b. DATE SIGNED
EXAMINER'S NAME (Type)		John Kehoe MD Riverdale, Md.						11-20-68
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS		23d. LOCATION (City or Town) (County) (State)		
BURIAL		11/22/68		GEORGE WASHINGTON MEM. PK.		HYATTSVILLE, PR. GEO. MD.		
24. FUNERAL DIRECTOR		25a. REC'D BY REGISTRAR ADDRESS						25b. REGISTRAR'S SIGNATURE
W.W. CHAMBERS Co., RIVERDALE, MD.								NOV 26 1968



16423

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

EDWARD W. SHAFFER

## CERTIFICATE OF DEATH

16423

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.  
 10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician or director, page 3 should be detached for use as the burial-transit permit. Then please move carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 DECEASED NAME (Type or print)	First	Middle	Last	2a. DATE OF DEATH Month Day Year	2b. HOUR 9:00 AM
EDWARD W. SHAFFER				Nov. 8 1968	11:00 M
3. SEX	4 RACE	S. DATE OF BIRTH	6. AGE (In years lost birthday)	IF UNDER 1 YEAR MONTHS DAYS	F. UNDER 24 HRS. HOURS MIN.
MALE	WHITE	3-26-1890	78 YRS		
7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH	Prince George Md	
Laurel, Mo.	U.S.				
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY		
DANIAH M.D. GARDEN	MAGNOLIA NURS. HOME	BROKER	REAL ESTATE		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13c. CITY OR TOWN	13d. INSIDE CITY LIMIT?	13e. STREET AND NUMBER		
D.C.	WASHINGTON	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	2727 29TH ST. N.W.		
14. FATHER'S NAME	First	Middle	Last	15. MOTHER'S MAIDEN NAME	First
CHARLES			SHAFFER		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	16b. SOCIAL SECURITY NO.	17. INFORMANT	APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
NO	-	RT. #1, DAVIDSONVILLE, MD. MRS. ELEANORA S. CARSON, DAUGHTER			
18. CAUSE OF DEATH (Enter on Y one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Congestive Heart Failure</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <u>41d4</u> (b) <u>Arterio-sclerotic heart disease</u> DUE TO, OR AS A CONSEQUENCE OF (c)					
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>Hypotension</u>					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
19c. MEDICAL CERTIFICATION	21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b.)		
	21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No	City or Town	County State
22a. I certify that (I) (this hospital) attended the deceased from <u>OCT 9</u> , 19 <u>68</u> , to <u>NOV 8</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>NOV 7</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>Leon Blevitsky</u>	DEGREE ATTENDING PHYS	<input checked="" type="checkbox"/> MED DIRECTOR	<input type="checkbox"/> STAFF PHYS	<input type="checkbox"/>	22c. DATE SIGNED <u>Nov 8 1968</u>
22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS <u>Leon Blevitsky, M.D.</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 11-11-1968	23c. NAME OF CEMETERY OR CREMATORIUM Ivy Hill Cemetery	23d. LOCATION (City or Town) (County) (State) Laurel, Prince Georges Co.		
24. FUNERAL DIRECTOR Joseph Gawler's Sons, Inc., N.W., Wash., D.C., 20016	ADDRESS 5130 Wisc. Ave.	25a. REC'D. BY REGISTRAR DATE NOV 12 1968	25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		



Item2lc Film 409 2-89 MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE  
HEALTH DEPT.

1642\*

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1642

1 DECEASED NAME (Type or Print)		First	Middle	Lost	2a DATE KNOWN OF ESTI- DEATH MATED	Month	Day	Year	2b HOUR		
		Charles	Otis	Shark		11	-10	68	19 5:45am		
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (in years last birthday)	7 IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9 COUNTY OF DEATH	2c DATE PRONOUNCED DEAD Month Day Year			
Male	Negro	8-25-1927	47 yrs				Prince George's	2d HOUR			
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8		9			10		
S.C.		U.S.A.									
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b KIND OF BUSINESS OR INDUSTRY			
Cheverly		Prince George Hospital			Cook			45 Govt			
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE		13c CITY OR TOWN		13d INSIDE CITY LIMITS?			13e STREET AND NUMBER				
District of Columbia		Washington		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			611 Anacostia Avenue				
14 FATHER'S NAME		First	Middle	Lost	15 MOTHER'S MAIDEN NAME	First	Middle	Lost	ADDRESS		
E Sips		Shark			Lula Ganzt				Olivia shark 611 Anacostia Ave		
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown)		16b SOCIAL SECURITY NO (If yes give year or dates of service)		17 INFORMANT			NE			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
Yes		WW2		Olivia shark			611 Anacostia Ave				
8. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Laceration of brain fr skull fracture											
3101 Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause lost Due to, or as a consequence of (b) and Shock from hemoperitoneum from liver Due to, or as a consequence of laceration (c)											
Minutes											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY?						
					YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>						
21a EXTERNA. CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b TIME OF INJURY Month, Day, Year HOUR A.M. 5:40am 11-10-1968		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) Passenger of car, thrown from car and struck by two other cars.							
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.) Access road from Kenilworth Ave. to Balt. Wash. Parkway, P.G. Co., Md.		21f LOCATION Street or R.F.D. No City or Town County State							
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE		John Kehoe MD			CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			22b DATE SIGNED 11-11-68			
EXAMINER'S NAME (Type)		Riverdale, Md.			ADDRESS (Street, city, town, or county)						
23a FOR AP. CREMATION, REMOVAL (Specify)		23b DATE 11-15-68		23c NAME OF CEMETERY OR CREMATORIAL Church Cemetery Canadys S.C.		23d LOCATION (City or Town) (County) (State)					
24 FUNERAL DIRECTOR		ADDRESS H. S. Washington 4925 Deanza Ave NE		25a REC'D BY REG STRAR DA NOV 14 1968		25b REGISTRAR'S SIGNATURE Charles Judge					

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil. Give Pages 1, 2, 3 & 4 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with farm report. 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial/transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.



FOR STATE  
HEALTH DEPT.



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if necessary, please execute the certificate, writing the word "pending" in pencil in Item 18 Give Pages 1, 2, 3, 4 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with farm files 5 may be retained for your files

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1 DECEASED-NAME (Type or Print)		First	Middle	Last	2a DATE KNOWN OF EST. DEATH MATED			Month	Day	Year	2b HOUR
		Steven	R	Shipe	<input checked="" type="checkbox"/> 11-24-68 19 ?						M
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (in years last birthday)	7 IF UNDER 1 YEAR MONTHS      DAYS	IF UNDER 24 HRS HOURS      MIN	2c DATE PRONOUNCED DEAD			2d HOUR		
Male	White	4-26-1952	16 YRS			<input checked="" type="checkbox"/> Month 11 Day 25 Year 68 19 8:21am M					
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9 COUNTY OF DEATH			Prince George's Md		
10 CITY OR TOWN OF DEATH  Cheverly		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)  Prince George Hospital				12a USUAL OCCUPATION (Kind of work done during most of working life even if retired.)			12b KIND OF BUSINESS OR INDUSTRY		
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Maryland		13b. COUNTY Prince George's		13c CITY OR TOWN Laurel	13d INSIDE CITY LIMITS?			13e STREET AND NUMBER 14 E Contee Road			
14 FATHER'S NAME First		Middle	Last	15 MOTHER'S MAIDEN NAME First			Middle	Last			
Charles W. Shipe				Beverly Anne Rhys							
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b SOCIAL SECURITY NO		17 INFORMANT			ADDRESS 14 E Contee Rd Beverly Shipe Laurel Md.			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
no				Beverly Shipe Laurel Md.							
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Gun shot wound of head											
DUE TO, OR AS A CONSEQUENCE OF 185 X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 176											
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED?				20 AUTOPSY?					
						<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO					
21a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b TIME OF INJURY Month, Day, Year HOUR A.M. PM 11-24-1968		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) Shot self with .22 cal rifle.			21f LOCATION Street or R.F.D. No. City or Town County State				
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.) Wooded area 20 yards in rear of home		21f LOCATION Street or R.F.D. No. City or Town same as #13							
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE EXAMINER'S NAME (Type)		John Kehoe MD Riverdale, Md.				CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ADDRESS (Street, City, town, or county)			22b DATE SIGNED 11-25-68		
23a BURIAL CREMATION BUTTERFLY (Specify)		23b DATE 11-27-68		23c NAME OF CEMETERY OR CREMATORIAL Mt. Lincoln			23d LOCATION (City or Town) Calmar Manor Md. (County) (State)				
24 FUNERAL DIRECTOR Klaeselan Funeral Home Laurel Md.		ADDRESS Klaeselan Funeral Home Laurel Md.					25a REC'D BY REGISTRAR NOV 29 1968			25b REC'D STAR'S SIGNATURE Charles Judge	
VR A15ME (5) TOM REV 1-68											



MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

164 11

CERTIFICATE OF DEATH

**10 HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.  
**Page 4** may be retained by the hospital or attending physician.

**10 FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 DECEASED NAME (Type or print)		First <b>Paul</b>	Middle <b>R</b>	Last <b>Shipley</b>	2d DATE OF DEATH Nov. Month <b>14</b> Day <b>1968</b>	2b HOUR <b>4:05 P.M.</b>			
3. SEX <b>male</b>	4 RACE <b>white</b>	5. DATE OF BIRTH <b>Dec 6, 1895</b>		6 AGE (In years last birthday) <b>72</b> YRS	IF UNDER 1 YEAR MONTHS <b>0</b>	IF UNDER 24 HRS HOURS <b>0</b>	2b HOUR MIN <b>00</b>		
7a BIRTHPLACE (State or foreign country) <b>Md</b>	7b CITIZEN OF WHAT COUNTRY? <b>S A</b>	B. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9 COUNTY OF DEATH <b>Prince George's</b>	Md				
10. CITY OR TOWN OF DEATH <b>Beltsville</b>	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>4909 Olympia ave</b>	12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>Retired Defence Dept</b>		12b KIND OF BUSINESS OR INDUSTRY <b>U.S. Government</b>					
13a USUAL RESIDENCE (Where deceased lived, if institution Res dence before admission) STATE <b>Md</b>	13b COUNTY <b>Pro Geo</b>	13c CITY OR TOWN <b>Beltsville</b>	13d. INSIDE CITY LIMITS? <b>YES</b> <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER <b>4909 Olympia ave.,</b>					
14 FATHER'S NAME <b>Ruben Shipley</b>	15. MOTHER'S MAIDEN NAME First <b>Margaret Corbey</b>			Middle	Last				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <b>yes</b>	16b. SOCIAL SECURITY NO <b>213 24 3633</b>	17. INFORMANT <b>Kathryn E Shipley</b>		Address <b>Beltsville, Md.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a)		<i>Cancer of the Lung</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>6 mths</b>					
1621 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c)							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>Arteriosclerotic Cardiovascular Disease</i>									
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify med. cal examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town		County	State			
22a. I certify that (I) (this hospital) attended the deceased from <b>April</b> , 1967, to <b>9 Nov.</b> , 1968, that (I) (we) last saw the deceased alive on <b>14 Nov.</b> , 1968, and that in my (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>Wm A. Winsatt</i>	22c. DEGREE <b>M.D.</b>	ATTENDING PHYS. <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS.	DATE SIGNED <b>14 Nov. 68</b>						
22d. PHYSICIAN'S NAME (Type) <b>Wm A Winsatt</b>	22e. ADDRESS <b>3415 Hamilton st</b>	Hyattsville, Md.							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>Nov 18, 1968</b>	23c. NAME OF CEMETERY OR CREMATORIAL <b>Christians Brothers cemetery</b>	23d. LOCATION (City or Town) <b>Ammendale</b>	(County) <b>Pro Geo</b>	(State) <b>Md.</b>				
24. FUNERAL DIRECTOR <b>F. Gasch's Sons</b>	ADDRESS <b>Hyattsville, Md.</b>	25a. REC'D BY REGISTRAR <b>Charles Judge</b>	25b. REGISTRAR'S SIGNATURE						
DATE <b>NOV 18 1968</b>									



**HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

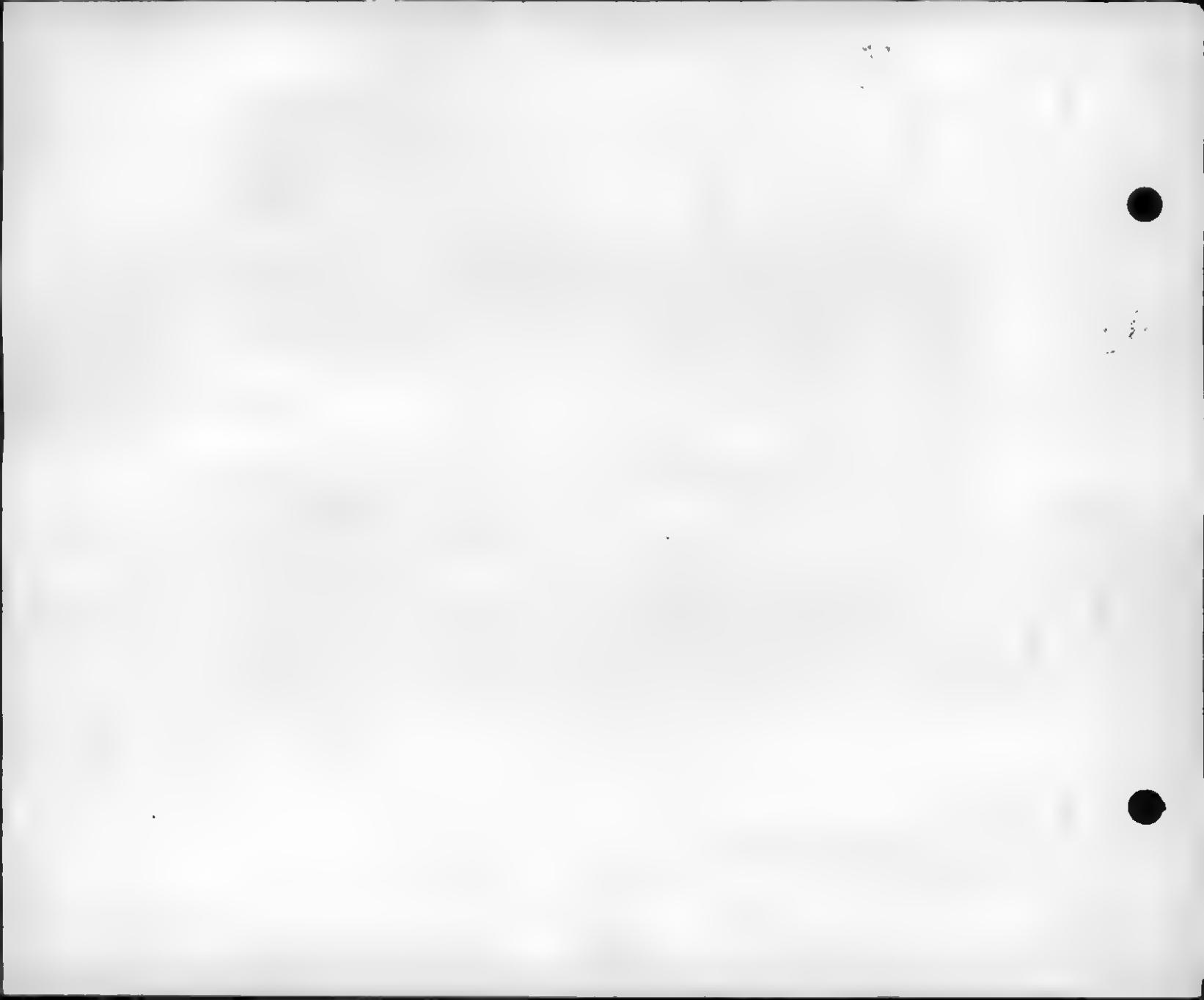
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

16427 16427

1. PLACE OF DEATH a. COUNTY PRINCE GEORGE MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY PRINCE GEORGE				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HYATTSVILLE	c. LENGTH OF STAY IN TB 9 YEARS	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HYATTSVILLE				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 1101 BURKETON STREET		d. STREET ADDRESS 1101 BURKETON STREET				
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED First GEORGE Middle EDWARD Last SIMONS	4. DATE OF DEATH NOV. 24 1968	Month NOV.	Day 24	Year 1968		
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH AUG 25, 1906	9. AGE (In years last birthday) 62 yrs	10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 0	11. IF UNDER 24 HRS Months 0 Days 0 Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RESTAURANT OWNER		10b. KIND OF BUSINESS OR INDUSTRY CATERING		11. BIRTHPLACE (County & State, or foreign country) WASHINGTON D.C.		12. CITIZEN OF WHAT COUNTRY? UNITED STATES
13. FATHER'S NAME PETER SIMONS		14. MOTHER'S MAIDEN NAME AMELIA SAROFIN				
15. WAS DECEASED EVER IN U.S. ARMEED FORCES? (Yes, no, or unknown) If yes give war or dates of service) NO.		16. SOCIAL SECURITY NO 579 12 5119		17. INFORMANT MRS CATHERINE SIMONS		Address 1101 BURKETON ST. HYATTSVILLE
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		CONGESTIVE HEART FAILURE		INTERVAL BETWEEN ONSET AND DEATH 6 MONTHS		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) last. 41X		RHEUMATIC HEART DISEASE		4 YEARS.		
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
20a. MEDICAL CERTIFICATION ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) H/A		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) N/A.				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Name, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from AUGUST, 1968 to NOV. 24, 1968, that (I) ( ) lost saw the deceased alive on NOV 23 1968, and that death occurred at 7:35 A.M. from causes and on the date stated above.						
22a. SIGNATURE Dennis J. Hand		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED NOV 24 1968		
22c. PHYSICIAN'S NAME (Type) DENNIS J. HAND MD		22d. ADDRESS 4600 CONNECTICUT AVE. NW. WASH. DC				
23a. BURIAL, CREMATION, REMOVAL (Specify) 11/27/1968		23b. DATE THEREOF 11/27/1968		23c. NAME OF CEMETERY OR CREMATORIAL SX INSTITUTE		23d. LOCATION (City or Town) (County) (State) WASH. D.C.
24. FUNERAL DIRECTOR Robert A. Mattingly		ADDRESS 181-44th St. N.W. WASH. D.C.		25a. REC'D BY REGISTRAR NOV 27 1968		25b. REGISTRAR'S SIGNATURE Charles Judge



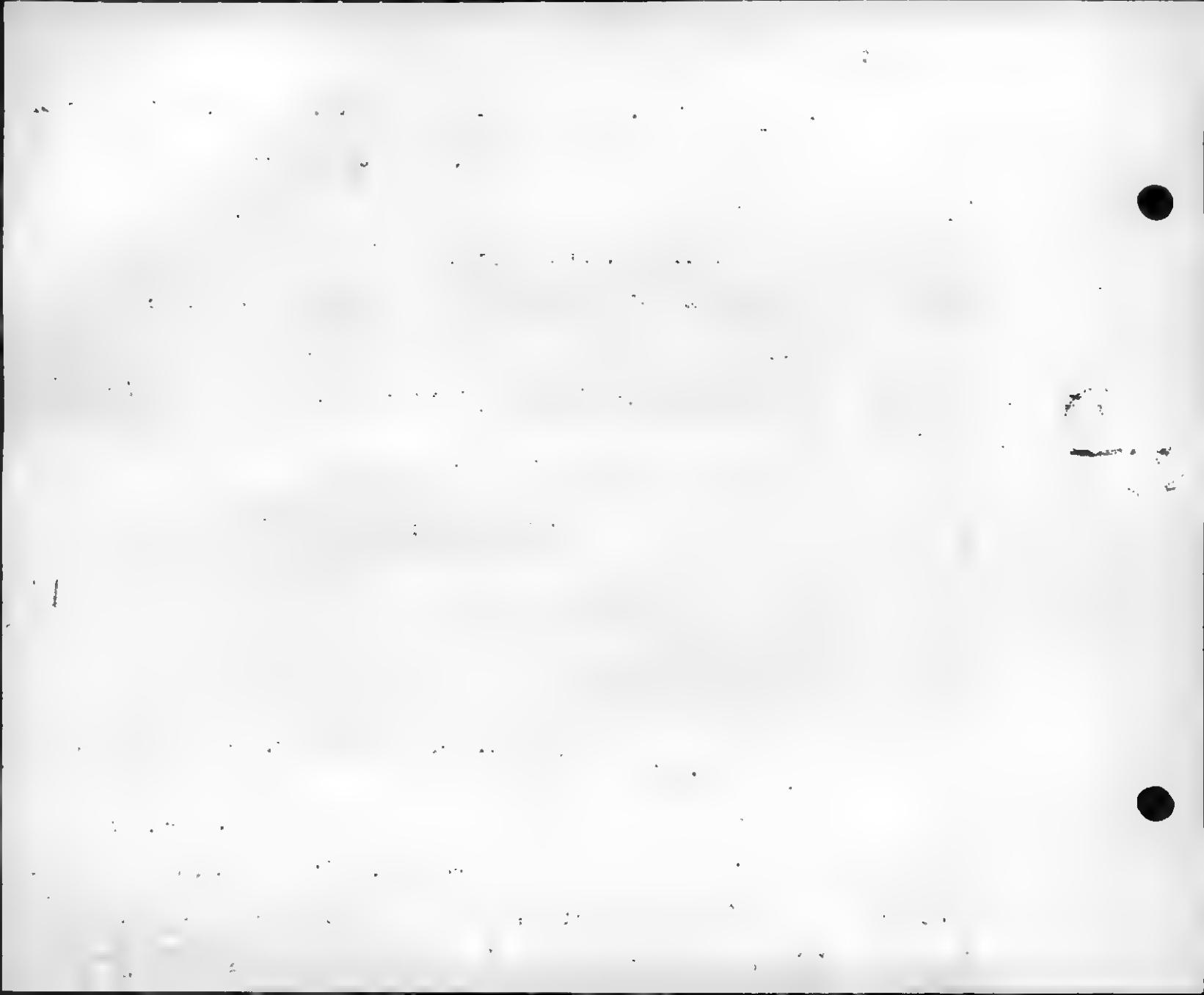
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

**10 HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.  
**10 FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print)		First <b>William</b>	Middle <b>H.</b>	Last <b>Skinner</b>	2a. DATE OF DEATH Month <b>Nov.</b>	Day <b>18,</b>	Year <b>1968</b>	2b. HOUR <b>5:15 P.M.</b>
3. SEX		4. RACE		5. DATE OF BIRTH	6. AGE (In years last birthday) <b>59</b>		IF UNDER 1 YEAR MONTHS <b>YRS.</b>	
<b>Male</b>		<b>Negro</b>		<b>Feb. 16, 1909</b>				
7a. BIRTHPLACE (State or foreign country) <b>Chas. Co. Md.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	9 COUNTY OF DEATH <b>Prince George's</b>		10c. IF UNDER 24 HRS. MONTHS <b>YRS.</b>	
10. CITY OR TOWN OF DEATH <b>Cheverly</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Prince Geo. Gen'l Hospital</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Laborer</b>		12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived if institution; Residence before admission) STATE <b>Maryland</b>		13b. COUNTY <b>Prince George's</b>		13c. CITY OR TOWN <b>Brandywine</b>	13d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input type="checkbox"/> NO	13e. STREET AND NUMBER <b>Route #1, Box 55</b>		
14. FATHER'S NAME First <b>James H. Skinner</b>		Middle <b></b>	Last <b></b>	15. MOTHER'S MAIDEN NAME First <b>Ida</b>	Middle <b></b>	Last <b>West</b>	Address <b>Above</b>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <b>No</b>		16b. SOCIAL SECURITY NO. <b>212-14-3202</b>		17. INFORMANT <b>Mrs. Catherine Greene -</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) DUE TO, OR AS A CONSEQUENCE OF <b>Dehydration. Hepatic coma</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) DUE TO, OR AS A CONSEQUENCE OF <b>Diarrhea. Chronic alcoholism</b> (c) <b>Malnutrition - Alcoholism</b>								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) / /								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? <input type="checkbox"/> YES <input type="checkbox"/> NO	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.	City or Town	County	State	
22a. I certify that <b>(he)</b> (this hospital) attended the deceased from <b>Oct. 18, 1968</b> , to <b>Nov. 18, 1968</b> , that <b>(he)</b> (we) last saw the deceased alive on <b>Nov. 18, 1968</b> , and that in <b>(our)</b> (our) opinion death occurred on the date and hour and from the causes stated above, <b>(he)</b> (we) did not view the body after death.								
22b. SIGNATURE <b>S. V. Nair, M. D.</b>		DEGREE <b>B.M.B.S.</b>	ATTENDING PHYS. <input type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input checked="" type="checkbox"/>	22c. DATE SIGNED <b>Nov. 19, 1968</b>		
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS <b>Prince Geo. Gen'l Hospital, Cheverly, Md.</b>						
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>11-22-68</b>		23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS <b>St. Mary's Ch. Cem.</b>		23d. LOCATION (City or Town) (County) (State) <b>Bryantown Chas. Co. Md.</b>		
24. FUNERAL DIRECTOR <b>Montell Adams, Opossele, Jr., M.D.</b>		25a. REC'D. BY REGISTRAR DATE <b>NOV 27 1968</b>						
		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>						



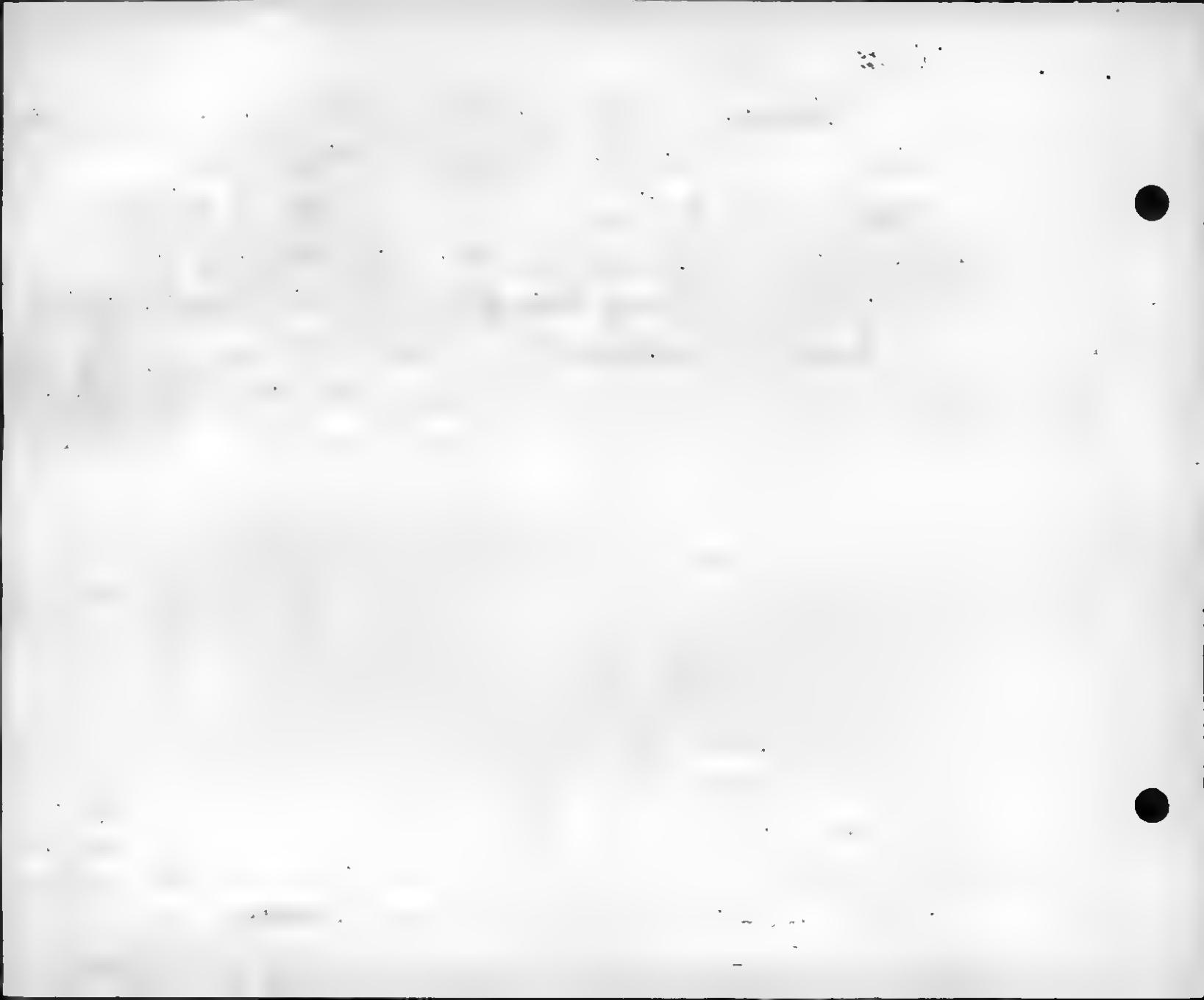
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.  
**Page 4 may be retained by the hospital or attending physician.**

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the offending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Please sign and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print)		First <i>Richard K.</i>	Middle <i>Small</i>	Last <i>Small</i>	2a. DATE OF DEATH Month <i>NOV.</i>	Day <i>13</i>	Year <i>1968</i>	2b. HOUR 10:30 P.M.			
3. SEX <i>Male</i>		4 RACE <i>White</i>	5. DATE OF BIRTH <i>Nov. 30-1903</i>		6. AGE (In years lost birthday) <i>64 yrs.</i>		7. IF UNDER 1 YEAR MONTHS DAYS		8. IF UNDER 24 HRS HOURS MIN.		
7a. BIRTHPLACE (State or foreign country) <i>Md.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED		9. COUNTY OF DEATH <i>Prince George</i>					
10. CITY OR TOWN OF DEATH <i>Camp Springs</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Andrew AFB Hosp</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>Real-Estate Broker</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Princ George</i>					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Md.</i>		13c. CITY OR TOWN <i>Pr Geo Clinton Acres</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <i>11800-Crestwood Ave</i>					
14. FATHER'S NAME First <i>Frances H.</i>		Middle <i>Small</i>	Last <i>Small</i>	15. MOTHER'S MAIDEN NAME First Middle <i>Annie NORRIS</i>		Address <i>Clinton Acres, Md</i>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <i>No</i>		16b. SOCIAL SECURITY NO <i>(If yes give war or dates of service)</i>		17. INFORMANT <i>Dorothy J. Small - 11800-Crestwood Ave</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>3 mos.</i>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Curiosis, Liver</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a). (b) stating the underlying cause last. (c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(c)											
MEDICAL CERTIFICATION		19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
		21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> <input type="checkbox"/> of work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING ETC.)		21f. LOCATION Street or R.F.D. No		City or Town		County		State	
22a. I certify that (I) (this hospital) attended the deceased from <i>Feb. 10, 1950</i> , to <i>Nov. 13, 1968</i> , that (I) (we) last saw the deceased alive on <i>11-12 1968</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>Frank S. Pellegrini MD</i>		22c. DEGREE <i>MD</i>		ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>		DATE SIGNED <i>11-13-68</i>	
22d. PHYSICIAN'S NAME (Type) <i>FRANK S. PELLEGRINI</i>		22e. ADDRESS <i>3611 Branch Ave SE Hillcrest Heights Md</i>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>11-18-68</i>		23c. NAME OF CEMETERY OR CREMATORIAL <i>Cedar Hill Cemetery</i>		23d. LOCATION (City or Town) <i>Syftland, Md</i>		(County)		(State)	
24. FUNERAL DIRECTOR <i>Simmons Bros.</i>		ADDRESS <i>1661-Good Hope Rd SE</i>		25a. REC'D BY REGISTRAR <i>NOV 15 1968</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>					



**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201**

## **CERTIFICATE OF DEATH**

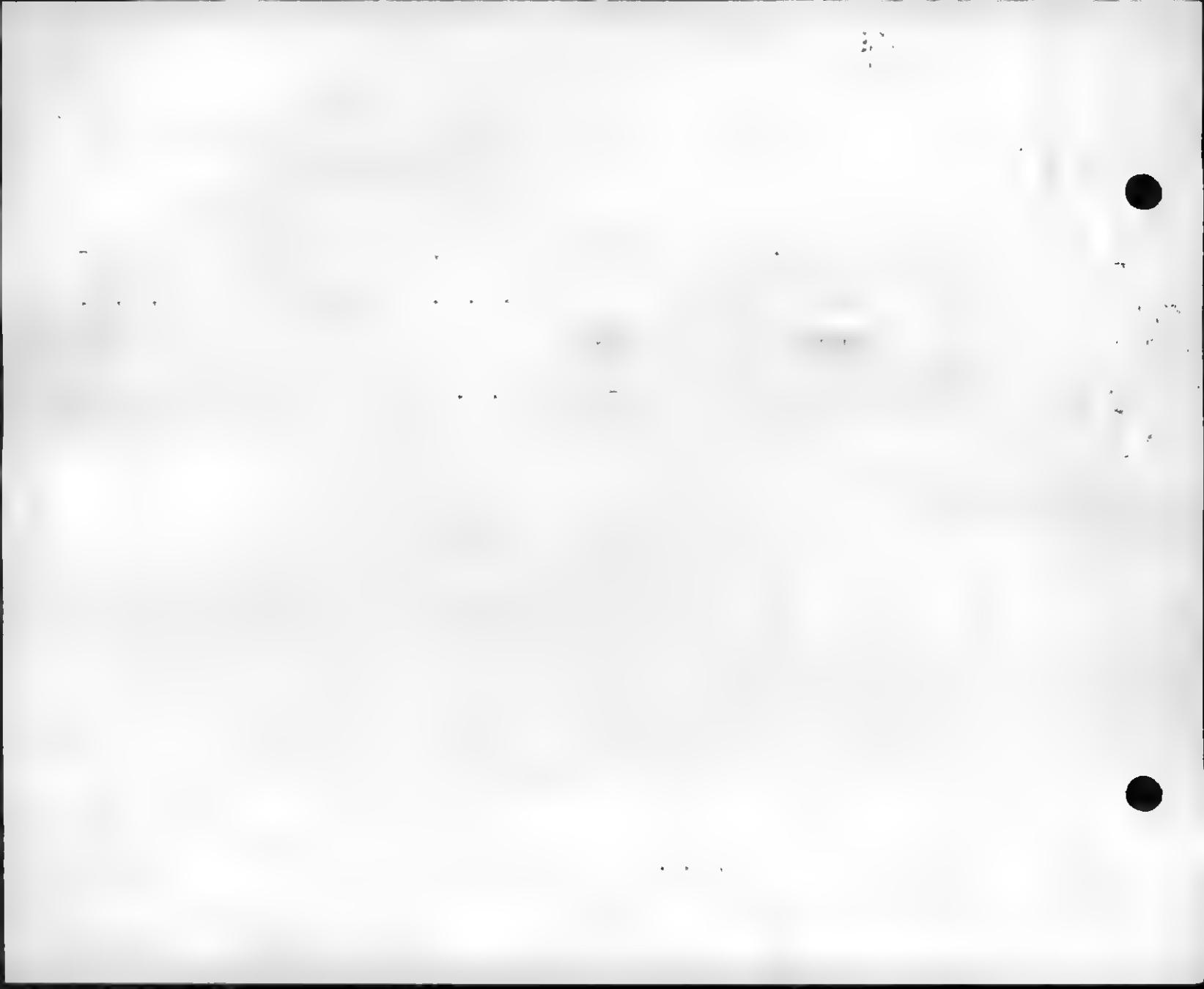
1644

16430

**HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the ~~death certificate~~ be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. ~~Page 3~~ and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

1. DECEASED-NAME (Type or print)	First <b>Elsie</b>	Middle	Last <b>Smith</b>	2a DATE OF DEATH Month <b>11</b>	Day <b>13</b>	Year <b>68</b>	2b. HOUR <b>8:45 AM</b>
3. SEX <b>Female</b>	4. RACE <b>Negro</b>	S. DATE OF BIRTH <b>2/28/1897</b>	6 AGE (in years less birthday) <b>71</b>	IF UNDER 1 YEAR MONTHS <b> </b>		IF UNDER 24 HRS HOURS <b> </b>	
7a. BIRTHPLACE (State or foreign country) <b>Maryland</b>	7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH <b>Prince George's</b>				
10. CITY OR TOWN OF DEATH <b>Glenn Dale, Md.</b>	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Glenn Dale Hosp.</b>	12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>Unknown</b>	12b KIND OF BUSINESS OR INDUSTRY <b>--</b>				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b> </b>	13b. COUNTY <b> </b>	13c. CITY OR TOWN <b>Wash. D. C.</b>	13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	13e STREET AND NUMBER <b>1325 Bryant St. N. E.</b>			
14. FATHER'S NAME First <b>David</b>	Middle <b>Gorman</b>	15. MOTHER'S MAIDEN NAME First <b>Sarah</b>	Middle <b>Freeland</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> Yes, no, or unknown <b>No</b>	16b. SOCIAL SECURITY NO <b>217-34-5275</b>	17. INFORMANT <b>D. C. General Hospital Records</b>	Address <b>24-48 hrs.</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Recurrent cerebrovascular accident</b> <b>4129</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last <b>Multiple old cerebrovascular accidents, bilateral</b>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b> </b>
DUE TO, OR AS A CONSEQUENCE OF (b) <b>Arteriosclerotic cardiovascular disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Chronic brain syndrome</b>							<b>24-48 hrs.</b>
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b> </b>							
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b> </b>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)	21f. LOCATION Street or R.F.D. No	City or Town		County	State	
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>9/23</b> , 19 <b>66</b> , to <b>11/13/</b> 19 <b>68</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>11/13/</b> 19 <b>68</b> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) did <input checked="" type="checkbox"/> (did not) view the body after death.							
22b. SIGNATURE <b>Moe Weiss</b>	DEGREE	ATTENDING PHYS.	<input type="checkbox"/> MED DIRECTOR	<input checked="" type="checkbox"/> STAFF PHYS.	22c. DATE SIGNED <b>11/13/68</b>		
22d. PHYSICIAN'S NAME (Type) <b>Moe Weiss, M.D.</b>	22e. ADDRESS <b>Glenn Dale Hospital</b> <b>Glenn Dale, Maryland</b>						
23a. BURIAL, CREMATION, REMOVAL (Specify) <b> </b>	23b. DATE <b>11-17-68</b>	23c. NAME OF CEMETERY OR CREMATORIAL <b>St Edmunds Ch. Cemetery Sunderland</b>	23d. LOCATION (City or Town) <b> </b>	(County) <b> </b>	(State) <b>MD</b>		
24. FUNERAL DIRECTOR <b>P. J. &amp; Son</b>	ADDRESS <b>Prince Frederick</b>	25a. REC'D BY REGISTRAR <b>NOV 18 1968</b>	25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>				



MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
CERTIFICATE OF DEATH.

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.  
**To FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print)			First <b>Lavinia</b>	Middle <b>M. B.</b>	Last <b>Smith</b>	2d. DATE OF DEATH Month <b>November</b>	Day <b>1, 1968</b>	Year <b>1968</b>	2b. HOUR <b>11:55 A.M.</b>		
3. SEX <b>Female</b>	4. RACE <b>White</b>	S. DATE OF BIRTH <b>July 23, 1876</b>	6. AGE (In years last birthday) <b>92 yrs.</b>			7. IF UNDER 1 YEAR MONTHS <b>0</b>			8. IF UNDER 24 HRS HOURS <b>0</b>		
7a. BIRTHPLACE (State or foreign country) <b>Maryland</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH <b>Prince Georges</b>								
10. CITY OR TOWN OF DEATH <b>Forestville</b>	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Regent Nursing Home</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>Housewife</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>				
13a. USJAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <b>Md.</b>	13b. COUNTY <b>Upper Marlboro</b>	13c. CITY OR TOWN <b>Pr. Geo's Marlboro</b>	13d. INSIDE CITY LIMITS? <b>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></b>	13e. STREET AND NUMBER <b>Box #8</b>							
14. FATHER'S NAME First <b>James Naylor Walls Wilson</b>	Middle --	Last --	15. MOTHER'S MAIDEN NAME First <b>Sarah</b>	Middle --	Last <b>Gibbons</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown? <b>No</b>	16b. SOCIAL SECURITY NO ---	17. INFORMANT <b>Mrs. Elizabeth Pumphrey</b>	Address <b>Box #8 Upper Marlboro Md.</b>								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (o) <b>4409</b>	DUE TO, OR AS A CONSEQUENCE OF <b>Coccyx 1/2</b>	APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 mos</b>									
Conditions, if any, which gave rise to immediate cause (o), stating the underlying cause lost. <b>4502</b>	(b) DUE TO, OR AS A CONSEQUENCE OF <b>Generalized Arteriosclerosis - see 1870</b>										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>4502</b>											
19a. DATE OF OPERATION <b>4502</b>	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) <b>At home, Farm, Street, Factory, Office Building, etc.</b>			21f. LOCATION Street or R.F.D. No <b>159a, 168, 1706, 19</b>			City or Town <b>Upper Marlboro</b>	County <b>Md.</b>	State <b>MD</b>	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)										
22a. I certify that (I) (this hospital) attended the deceased from <b>15 Jan 1968</b> , to <b>1 Nov 1968</b> , 19 saw the deceased alive on <b>Oct. 1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>Robert Basscer</b>	DEGREE <b>MD</b>	ATTENDING PHYS <input checked="" type="checkbox"/>	MED DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	22c. DATE SIGNED <b>Nov. 1, 1968</b>						
22d. PHYSICIAN'S NAME (Type) <b>Robert B. Basscer, M. D.</b>	22e. ADDRESS <b>Upper Marlboro, Md. 20870</b>										
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>11/4/68</b>	23c. NAME OF CEMETERY OR CREMATORIAL <b>Trinity Cemetery</b>			23d. LOCATION (City or Town) (County) (State) <b>Upper Marlboro Pr. Geo. Md.</b>						
24. FUNERAL DIRECTOR <b>Ritchie Bros. Upper Marlboro, Md.</b>	ADDRESS				25a. REG'D BY REGISTRAR <b>NOV 12 1968</b>	25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>					



**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201**

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print) Lawrence			First	Middle	Last	2a DATE OF DEATH Nov. 1, 1968	2b. HOUR 7:05 A
3 SEX <b>Male</b>	4 RACE <b>Negro</b>				5 DATE OF BIRTH <b>Jan 13-1913</b>	6 AGE (in years last birthday) <b>65 55 yrs</b>	F UNDER 1 YEAR MONTHS DAYS HOURS MN
7b. BIRTHPLACE (State or foreign country) <b>VA</b>		7b CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED	9 COUNTY OF DEATH <b>Prince George's</b>		
10. CITY OR TOWN OF DEATH <b>Cheverly</b>		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Prince Geo.Gen'l Hospital</b>			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>Construction Worker</b>		12b KIND OF BUSINESS OR INDSTRY <b>Construction</b>
13a USUAL RESIDENCE (Where deceased lived if institution Residence before admission) <b>Maryland</b>		13b COUNTY <b>Prince George's</b>	13c CITY OR TOWN <b>Cedar Hgts.</b>	13d INSIDE CITY LIMITS? <input type="checkbox"/> YES <input type="checkbox"/> NO	13e STREET AND NUMBER <b>1116 64th Ave.</b>		
14 FATHER'S NAME <b>Joseph Smith</b>		First	Middle	Lost	15 MOTHER'S MAIDEN NAME First <b>Sally</b>	Middle	Lost
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <b>No</b>		16b SOCIAL SECURITY NO. <b>Noe</b>		17 INFORMANT <b>Lawrence Smith Jr 1226 New st. N.E.</b>	Address		
18. CAUSE OF DEATH (Enter as many causes per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>CARDIAC AND RESPIRATORY ARREST</b> Approximate interval between onset and death <b>15 14</b>							
DUE TO, OR AS A CONSEQUENCE OF (b) <b>Endocrine, i.e., perspiration - Brain metastasis</b>							
DUE TO, OR AS A CONSEQUENCE OF (c) <b>Carcinoma of the pancreas.</b>							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) <b>15 14</b>							
19a DATE OF OPERATION <b>15/14</b>		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <input checked="" type="checkbox"/>		
21a ACCIDENT WAS UNDERLYING OR CONTRIBUTING (If either, notify medical examiner) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		21b TIME OF INJURY .. HOUR A.M. Month Day Year PM 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY (OFFICE BUILDING, ETC)		21f. LOCATION Street or RFD No	City or Town	County	State
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>Oct. 18, 1968</b> , to <b>Nov. 1, 1968</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>Nov. 1, 1968</b> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above <input checked="" type="checkbox"/> (we) (did) <input checked="" type="checkbox"/> view the body after death							
22b SIGNATURE <b>Luis Bentolila</b>		DEGREE <b>MD</b>	ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS	22c DATE SIGNED <b>Nov. 1, 1968</b>			
22d PHYSICIAN'S NAME (Type) <b>Luis Bentolila, M.D.</b>		22e ADDRESS <b>Prince Geo.Gen'l Hospital, Cheverly, Md.</b>					
23a BURIAL, CREMATION, REMOVAL (Specify) <input checked="" type="checkbox"/>		23b DATE <b>11-5-68</b>	23c NAME OF CEMETERY OR CREMATORIAL <b>CARVER</b>		23d. LOCATION (City or Town) <b>Markham Rd</b> (County) <b>MD</b> (State)		
24 FUNERAL DIRECTOR <b>H.S. Washington &amp; Sons</b>		ADDRESS <b>4925 Wayne Ave NE</b>	25e REC'D BY REGISTRAR <b>NOV 6 1968</b>		25b REGISTRAR'S SIGNATURE <b>Charles Judge</b>		



1644

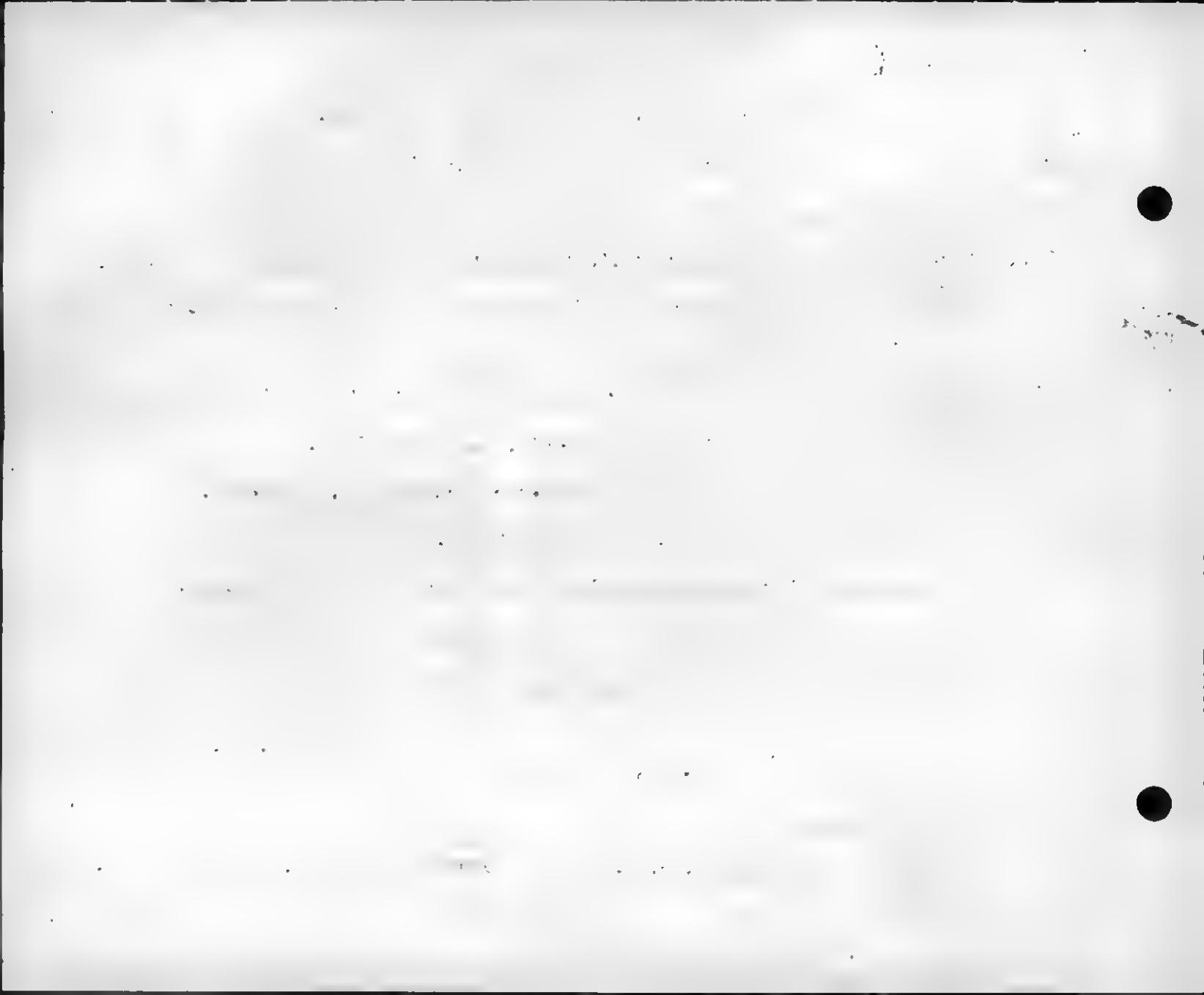
16433

## CERTIFICATE OF DEATH

1 DECEASED NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH	2b. HOUR
Clarence			O.	Stephens	Nov. 11, 1968	11:15 <sup>A</sup>	
3. SEX		4. RACE	S. DATE OF BIRTH			6. AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN
Male		Caucasian	12/29/91			76 yrs.	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH	
Indiana		U.S.A.				Prince George's	Md
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUA. OCCUPATION (Kind of work done during most of working life even if retired)		12b. KIND OF BUSINESS OR INDUSTRY
Cheverly		Prince Geo. Gen'l Hospital			Diamond		cutter
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE		13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER		
Maryland		Prince George's	College Park		4607 Beech Wood Road		
14. FATHER'S NAME		First	Middle	Last	15. MOTHER'S MAIDEN NAME	First	Middle
		Wm S	Stephens		Effie		Last
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown)		16b. SOCIAL SECURITY NO		17. INFORMANT		Address	
no		479 03 2564A		Kennard Stephens		College Park, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))							
PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Broncho-pneumonia, left lower lobe.  510X							
DUE TO, OR AS A CONSEQUENCE OF Cause(s), if any, which gave rise to immediate cause (a), stating the underlying cause last. 605X							
(b) Acute suppurative pyelonephritis, bilateral. DUE TO, OR AS A CONSEQUENCE OF (c) Acute purulent cystitis.							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
Medical Certification							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
					YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	Yes	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION	Street or R.F.D. No.	City or Town	County State
22a. I certify that (I) (this hospital) attended the deceased from <u>11/11/68</u> , to <u>Nov. 11, 1968</u> , that (I) ( <input checked="" type="checkbox"/> ) last saw the deceased alive on <u>Nov. 11, 1968</u> , and that in (my) <input checked="" type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above, (I) ( <input checked="" type="checkbox"/> ) did <input checked="" type="checkbox"/> review the body after death.							
22b. SIGNATURE <i>Albert Roth</i>		DEGREE	ATTENDING PHYS.	<input checked="" type="checkbox"/> MED DIRECTOR	<input type="checkbox"/> STAFF PHYS.	22c. DATE SIGNED <u>11-12-68</u>	
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS Albert Roth, M. D. 5409 Riverdale Rd., Riverdale, Md. 20840					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 11/15/68	23c. NAME OF CEMETERY OR CREMATORIUM Ft Lincoln Cemetery		23d. LOCATION (City or Town) (County) (State) Colmar Manor Pro Geo Md.		
24. FUNERAL DIRECTOR		ADDRESS F. Gasch's Sons Hyattsville, Md.		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE DATE NOV 18 1968 <i>Charles Judge</i>	

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be filed within 24 hours after death.

10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

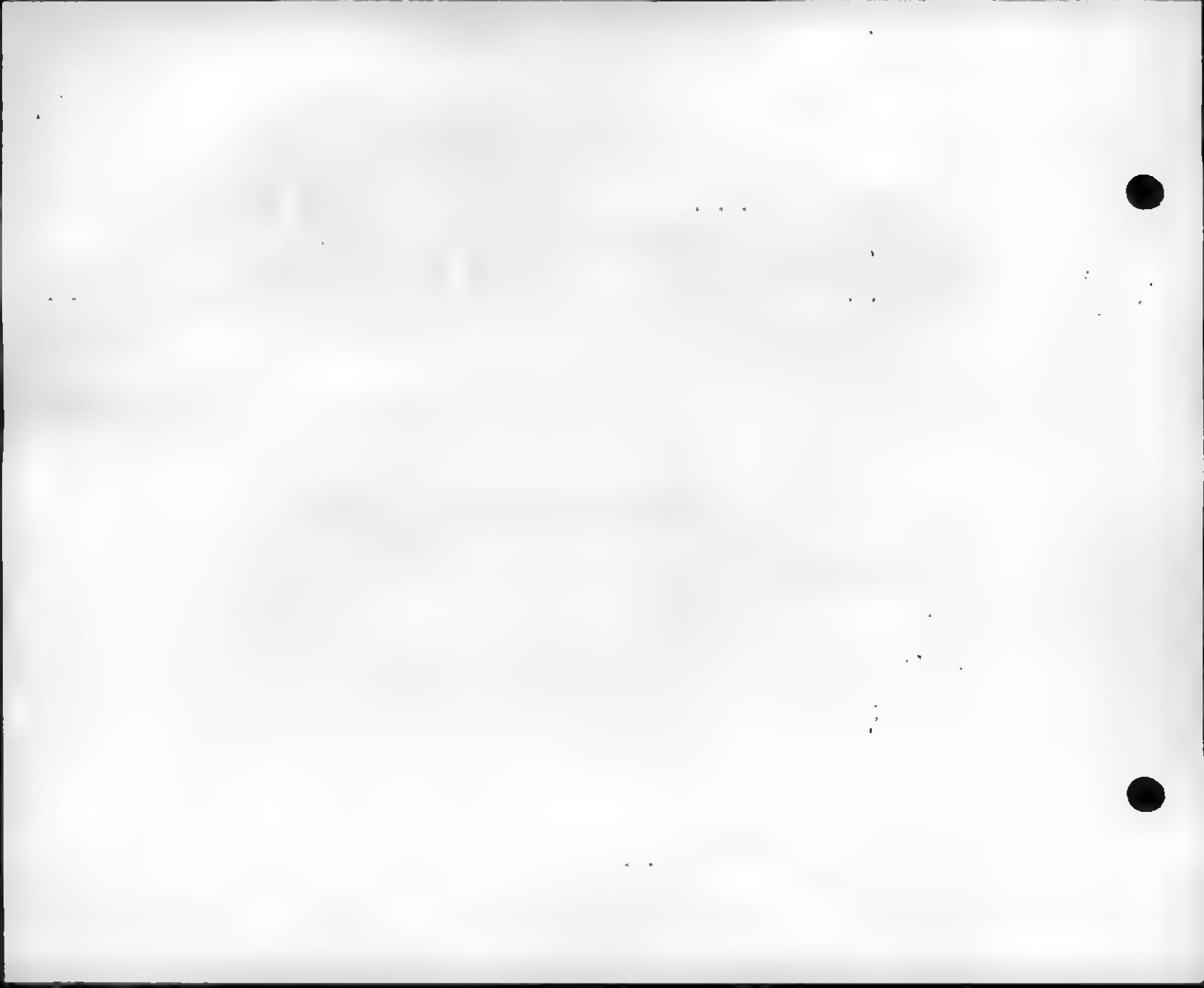
CERTIFICATE OF DEATH

16436 16436

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print)		First <b>Martha</b>	Middle <b>Jane</b>	Lost <b>Stevens</b>	2a. DATE OF DEATH Month <b>November</b>	Day <b>29</b>	Year <b>1968</b>	2b. HOUR <b>2:45 A.M.</b>		
3. SEX		4 RACE <b>Negro</b>		5. DATE OF BIRTH <b>June 9, 1910</b>		6 AGE (in years lost birthday) <b>58 YRS.</b>		IF UNDER 1 YEAR MONTHS	IF UNDER 24 HRS. HOURS	IF UNDER 24 HRS. MIN.
7a BIRTHPLACE (State or foreign country) <b>Virginia</b>		7b CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/>		9 COUNTY OF DEATH <b>Prince Georges</b>				
10. CITY OR TOWN OF DEATH <b>Glenn Dale</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Glenn Dale Hospital</b>		12a. USUAL OCCUPATION (Kind of work done during last year of life, even if retired.) <b>Domestic</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>--</b>				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>D.C.</b>		13b. COUNTY <b>V</b>		13c. CITY OR TOWN <b>Washington</b>		13d. INSIDE CITY LIMITS? <b>YES X NO</b>	13e. STREET AND NUMBER <b>1444 Harvard Street N.W.</b>			
14. FATHER'S NAME First <b>Henry</b>		Middle <b>Taylor</b>	Lost	15. MOTHER'S MAIDEN NAME First <b>Hattie</b>		Middle	Lost <b>Watkins</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, unknown <b>No</b>		16b. SOCIAL SECURITY NO <b>578-28-0420</b>		17 INFORMANT <b>Decedent</b>		Address				
<p>18. CAUSE OF DEATH (Enter on a separate line for (a), (b), and (c))          PART 1. DEATH WAS CAUSED BY          IMMEDIATE CAUSE (a) <b>Septicemia and bilateral bronchopneumonia</b> APPROXIMATE INTERVAL          BETWEEN ONSET AND DEATH <b>4 days</b></p> <p>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) <b>Urinary tract infection</b> years          (c) <b>Osteoarthritis, multiple joints</b> years</p>										
<p>PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(c)  <b>Arteriosclerotic heart disease; obesity</b></p>										
MEDICAL CERTIFICATION		19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
		21a. ACC DENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No		City or Town	County	State		
<p>22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>9/25/68</b>, to <b>11/29/68</b>, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>11/29/68</b>, and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) <input type="checkbox"/> view the body after death.</p>										
22b. SIGNATURE <i>Moe Weiss</i>		22c. DEGREE PHYS.		22d. ADDRESS <b>Glenn Dale Hospital</b>		22e. DATE SIGNED <b>11/29/68</b>				
22d. PHYSICIAN'S NAME (Type) <b>Moe Weiss, M.D.</b>										
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>12/1/68</b>		23c. NAME OF CEMETERY OR CREMATORIUM <b>Leesburg</b>		23d. LOCATION (City or Town) <b>Leesburg Loudon</b>		(County) (State) <b>Loudon VA</b>		
24. FUNERAL DIRECTOR <b>Jyson Wheeler Funeral Home</b>		133 ADDRESS <b>Rockville Pike</b>		25a. REC'D BY REGISTRAR DATE <b>DEC 4 1968</b>		25b. REGISTRAR'S SIGNATURE <i>Clarence J. Weiss</i>				



MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

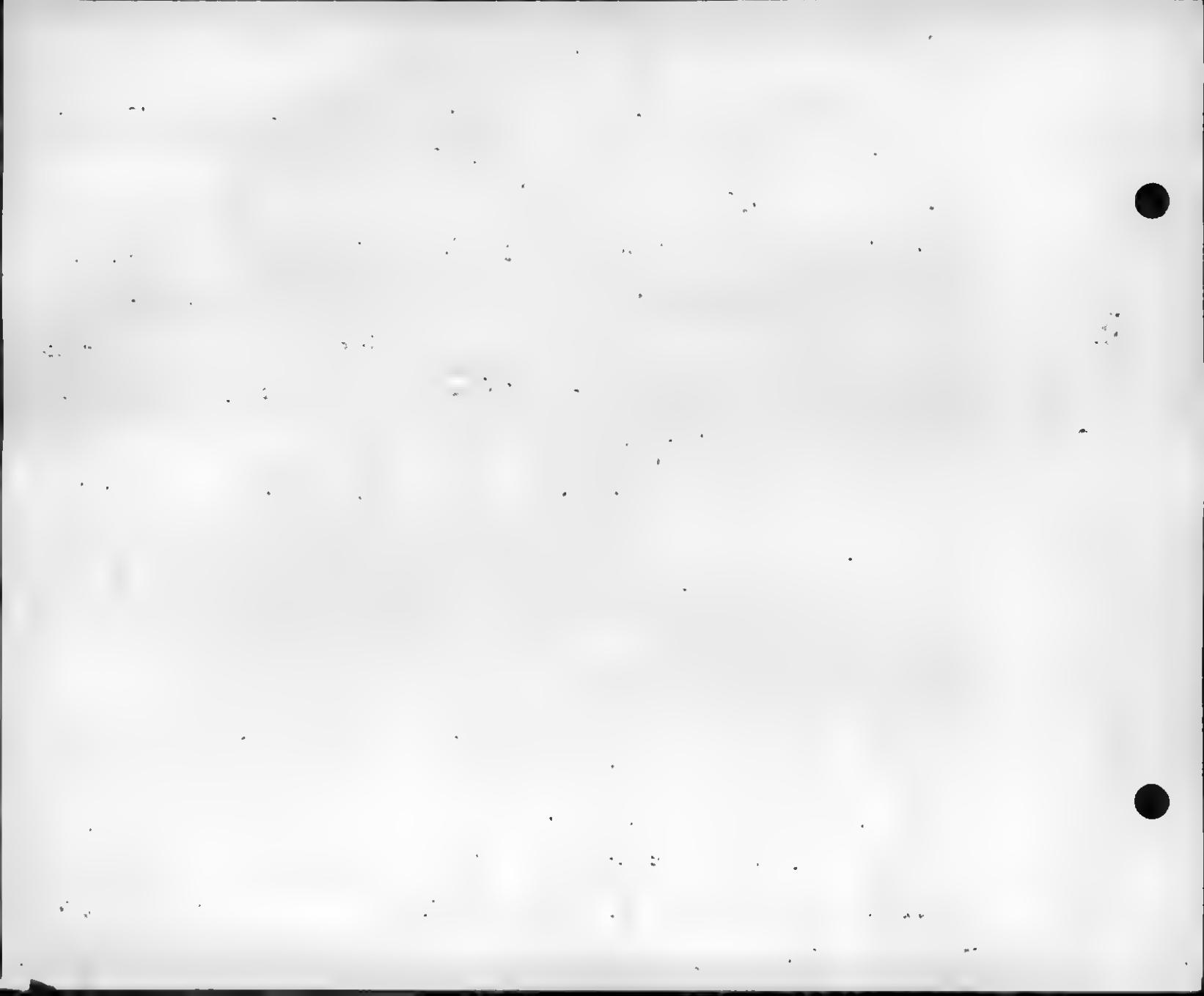
16435

16435

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after the funeral. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, with n 72 hours after death.

1. DECEASED-NAME (Type or print)		First <i>Ruth</i>	Middle <i>A.</i>	Lost <i>Streeter</i>	2d. DATE OF DEATH Month <i>Nov.</i> Day <i>25</i> Year <i>1968</i>	2b. HOUR <i>2:40 P.M.</i>
3. SEX <i>Female</i>	4 RACE <i>White</i>	S. DATE OF BIRTH <i>Oct. 25, 1898</i>		6 AGE (in years lost birthday) <i>70</i> YRS	IF UNDER 1 YEAR MONTHS <i>0</i>	IF UNDER 24 HRS HOURS <i>0</i>
7a BIRTHPLACE (State or foreign country) <i>Maryland</i>	7b CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Prince Georges</i>		
10 CITY OR TOWN OF DEATH <i>Hyattsville</i>	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Hyattsville Nursing Home</i>		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Housewife</i>		12b KIND OF BUSINESS OR INDSTRY <i>own home</i>	
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <i>Md.</i>	13b. COUNTY <i>Montgomery</i>	13c CITY OR TOWN <i>Sil.Spr.</i>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e STREET AND NUMBER <i>614 Sligo Avenue</i>		
14. FATHER'S NAME First <i>August</i>	Middle <i>Spieckerman</i>	15. MOTHER'S MAIDEN NAME First <i>Emily</i>		Middle <i>Maddox</i>	Last	
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <i>No</i>	16b SOCIAL SECURITY NO <i>579-32-4444</i>	17. INFORMANT <i>Relative</i>	Address <i>Harold Streeter 614 Sligo Avenue, S.S., Md.</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)						
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Respiratory arrest</i> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>mins.</i>						
DUE TO, OR AS A CONSEQUENCE OF: Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause <i>Brain tumor - inoperable</i> 9 mo. 5.						
DUE TO, OR AS A CONSEQUENCE OF: (c)						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>Parkinson's disease; Generalized arteriosclerosis</i>						
19a DATE OF OPERATION	19b CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
MEDICAL CERTIFICATION						
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State	
22a. I certify that (I) (this hospital) attended the deceased from <i>September, 1968</i> , to <i>Nov 25, 1968</i> , that (I) (we) last saw the deceased alive on <i>September 19, 1968</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE <i>Harold W. Draper, M.D.</i>						
22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS <i>9801 Georgia Ave. Silver Spring,</i>		ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	22f. DATE SIGNED <i>26 November, 68</i>
23a. BURIAL, CREMATION, REMOVAL, ETC. <i>Cremation</i>	23b. DATE <i>-11-27-1968</i>	23c. NAME OF CEMETERY OR CREMATORIAL <i>St. Lincoln Crematory</i>	23d. LOCATION (City or Town) (County) (State) <i>Prince Georges, Maryland</i>			
24. FUNERAL DIRECTOR <i>J.W. Lee</i>	ADDRESS <i>Sil.Spr. Md.</i>		25a. REC'D BY REGISTRAR DATE <i>NOV 29 1968</i>	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		
VR A 15 (1) 30M REV. 1-68						



FOR STATE  
HEALTH DEPT.

16436  
1  
164511  
Any delay is  
necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2 and 3 to  
the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with farm PM3 Page  
5 may be retained for your files  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with immediate Department of  
Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. DECEASED NAME (Type or Print)			First	Middle	Last	20. DATE KNOWN OF ESTI- DEATH MATED	Month	Day	Year	2b. HOUR
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (in years last birthday)	IF UNDER 1 YEAR	F. UNDER 24 HRS					
Male	White	1-31-1920	48 yrs	MONTHS	DAYS	HOURS	MIN		2d. HOUR	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED	NEVER MARRIED	2c. DATE PRONOUNCED DEAD				
Maryland		U.S.A.		<input checked="" type="checkbox"/>	<input type="checkbox"/>	Month	Day	Year		
				WIDOWED	<input type="checkbox"/>	11-20-68 19 4:58pm				
				DIVORCED	<input type="checkbox"/>	20. DATE REC'D BY REGISTRAR				
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)				12b. KIND OF BUSINESS OR INDUSTRY
Riverdale		Belmont Hospital				Waitress				
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER			
Maryland		Prince George's		Adelphi		<input checked="" type="checkbox"/>	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		2211 Tecumseh Street	
14. FATHER'S NAME		First	Middle	Last	15. MOTHER'S MAIDEN NAME	First	Middle	Last		
		James	Sullivan		Margaret Pfiffer					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or Unknown)		16b. SOCIAL SECURITY NO		17. INFORMANT		ADDRESS				
Yes		7711		Eleanor Sullivan - above address (Wife)						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY		IMMEDIATE CAUSE (a) <u>Laceration of brain</u> DUE TO OR AS A CONSEQUENCE OF <u>Skull fracture</u>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost		(b) <u>Trauma - auto accident</u> DUE TO, OR AS A CONSEQUENCE OF								
		(c)								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(o)										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?				
						<input checked="" type="checkbox"/> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR AM		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b)						
21d. INJURY OCCURRED AT HOME <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No.		City or Town		County		State
		U.S. Rt 1 near Conte Road, Laurel, Prince George County, Maryland								
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>										
ACTUAL SIGNATURE		<u>John Kehoe</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ADDRESS (Street, city, town, or county)				22b. DATE SIGNED
EXAMINER'S NAME (Type)		John Kehoe MD Riverdale, Md.								11-21-68
23a. BURIAL, CREMATION REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL		23d. LOCATION (City or Town)		(County)		(State)
Burial		11/23/68		Columbia Gardens Cem.		Arlington, Va.				
24. FUNERAL DIRECTOR		Nalley's Funeral Home Inc.		ADDRESS Rainier, Maryland		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
								Charles Judge		
						DATE NOV 6 1968				



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with farm 5 may be retained for your files.

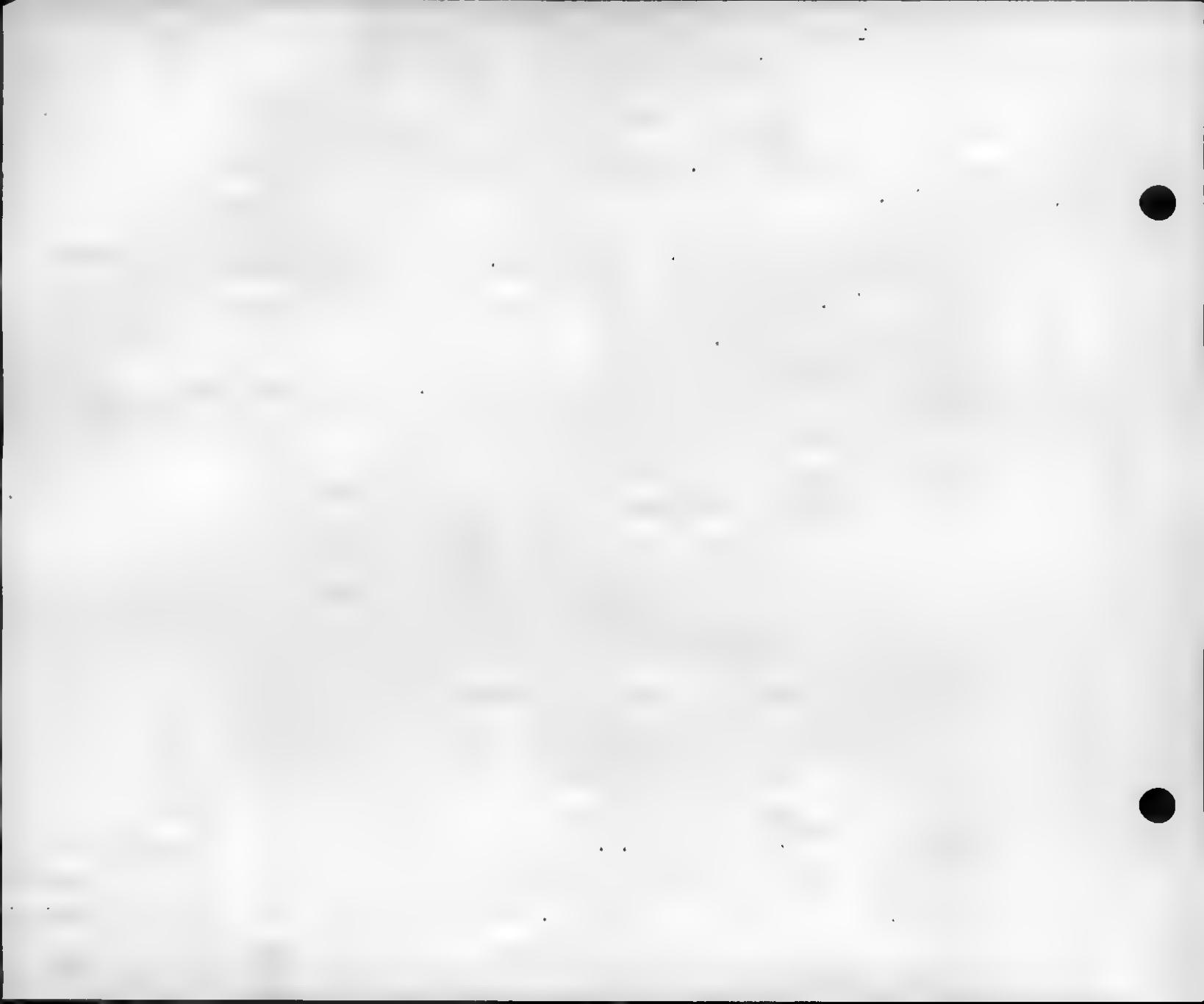
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1643 1643

1 DECEASED NAME (Type or Print)		First  Opal	Middle  Pope	Last  Tanner	2a DATE KNOWN OF ESTI- DEATH MATED <input checked="" type="checkbox"/>	Month 10	Day 3	Year 1968	2b HOUR am 1:00	
3 SEX F	4 RACE W	S DATE OF BIRTH 5 Oct 1900	6 AGE (in years last birthday) 59 yrs	IF UNDER MONTHS DAYS	YEAR HOURS MIN	2c. DATE PRONOUNCED DEAD Month 11 Day 3 Year 1968				
7a. BIRTHPLACE (State or foreign country) Miss.		7b CITIZEN OF WHAT COUNTRY? U S A		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Prince George				2d HOUR 2d HOUR 10:07 am	
10 CITY OR TOWN OF DEATH Cheverly		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Prince George Hosp.			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) House wife			12b KND OF BUS NESS OR INDLSTRY Own Home		
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Miss.		13c CITY OR TOWN Union		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e STREET AND NUMBER New Highway 15					
14 FATHER'S NAME Charles		First A.	Middle Pope	Last	15 MOTHER'S MAIDEN NAME Mattie	First B	Middle Short	Last		
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes No)		16b SOCIAL SECURITY NO		17. INFORMANT Arthur C. Tanner same as 13				ADDRESS		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Heart failure 3949 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Rheumatic valvular heart disease DUE TO, OR AS A CONSEQUENCE OF (c)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH over 20 yrs.	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) w/14:										
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED?							20 AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)						
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f LOCATION Street or R.F.D. No		City or Town		County	State	
22a I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>										
ACTUAL SIGNATURE  John Kehoe, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ADDRESS (Street, city, town, or county) Francis Gasch's Sons Hyattsville, Maryland								22b DATE SIGNED 11-3-68
23a BURIAL/CREMATION, REMOVAL (Specify) Burial		23b DATE 11/6/68		23c NAME OF CEMETERY OR CREMATORIAL Vista Mor. Park Cemetery		23d LOCATION (City or Town) New Albany		(County) Union		(State) Mississippi
24 FUNERAL DIRECTOR		ADDRESS		25a REC'D BY REGISTRAR		25b REGISTRAR'S SIGNATURE				
Francis Gasch's Sons Hyattsville, Maryland				DATE NOV 6 1968		Charles Judge				



MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

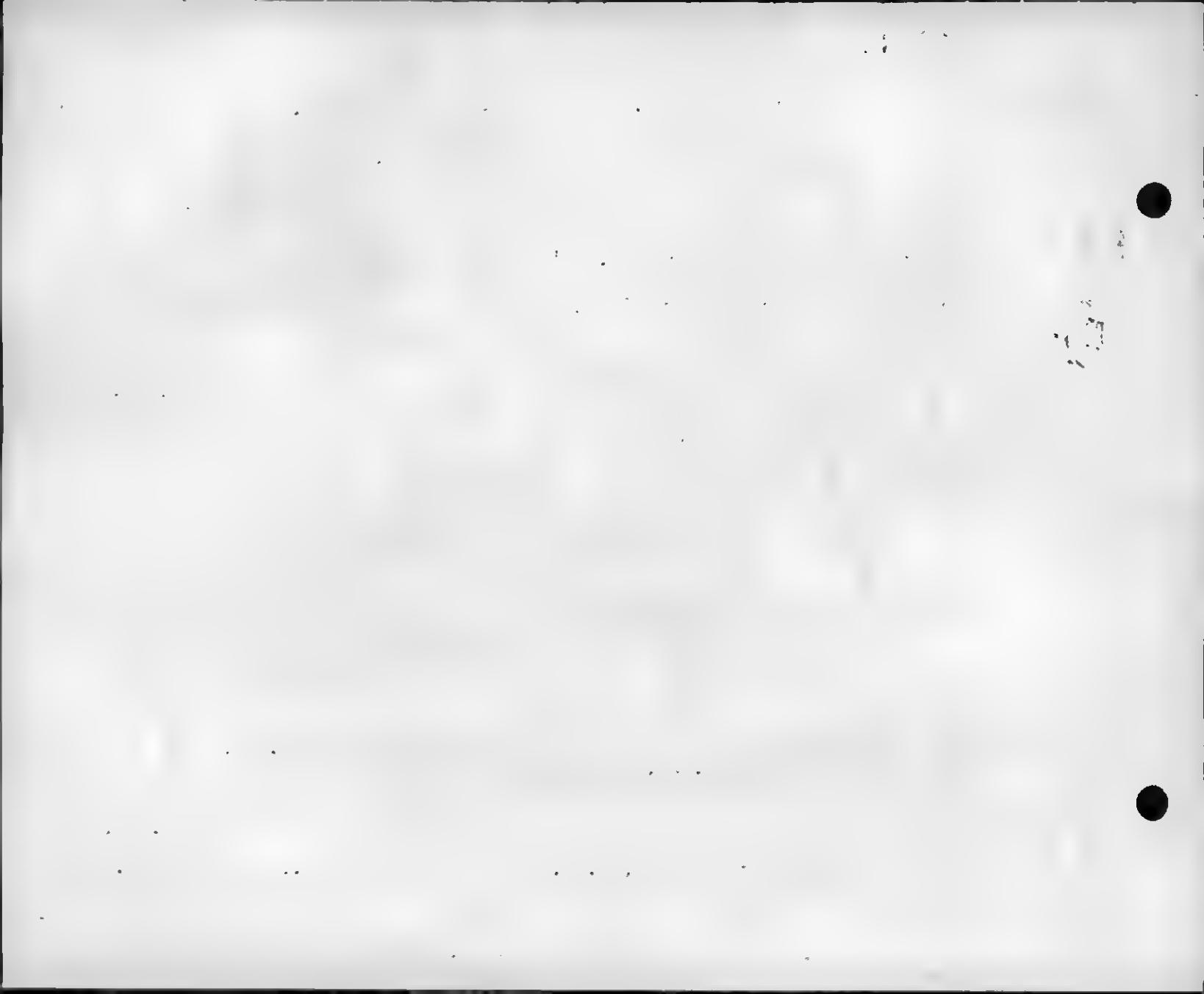
CERTIFICATE OF DEATH

**10 HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

42  
Page 4 may be retained by the hospital or attending physician.

**10 FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. This should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

16438		1645					
1. DECEASED NAME (Type or print)		First <b>Joseph</b>	Middle <b>D.</b>	Lost <b>Tevis</b>	2d DATE OF DEATH Month <b>Nov.</b> Day <b>26,</b> Year <b>1968</b>	26 HOUR <b>5:45AM</b>	
3 SEX <b>Male</b>		4 RACE <b>Caucasian</b>		S DATE OF BIRTH <b>August 19, 1907</b>	6 AGE (In years lost birthday) <b>61</b> YRS	IF UNDER 1 YEAR MONTHS <b>0</b> DAYS <b>0</b> HOURS <b>0</b> MIN <b>0</b>	
7a BIRTHPLACE (State or foreign country) <b>Pa</b>		7b CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9 COUNTY OF DEATH <b>Prince George's</b>	Md	
10 CITY OR TOWN OF DEATH <b>Cheverly</b>		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Prince Geo. Gen'l Hospital</b>		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>Book Binder</b>	12b KIND OF BUSINESS OR INDUSTRY <b>S Gov't</b>		
3a U.S. RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <b>Maryland</b>		3c CITY OR TOWN <b>Chillum</b>		13d INS OF CTY. UNITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e STREET AND NUMBER <b>5803 Sargent Road</b>		
14. FATHER'S NAME First <b>William Tevis</b>		15. MOTHER'S MAIDEN NAME First <b>Lillian Skelton</b>					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <b>No</b>		16b SOCIAL SECURITY NO <b>168 01 8779</b>		17 INFORMANT <b>Mollie S Tevis</b> Address <b>Hyattsville, Md.</b>			
18. CAUSE OF DEATH (Enter on a line per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>403 X</b>		DUE TO, OR AS A CONSEQUENCE OF <b>Neumon</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 months</b>			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause <b>lost</b>		(b) <b>Chronic Myopathy</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Generalized Arteriosclerosis</b>		10 years			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(c)							
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>XXX</b>		
21a ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b)			
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME FARM STREET, FACTORY) (OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No	City or Town	County	State
22a. I certify that (I) <b>Chamnes Sahakyan</b> attended the deceased from <b>Nov. 26, 1968</b> , to <b>Nov. 26, 1968</b> , that (I) <b>last</b> saw the deceased alive on <b>Nov. 26, 1968</b> , and that in (my) <b>opinion</b> death occurred on the date and hour and from the causes stated above, (I) <b>did</b> <b>not</b> <b>view</b> the body after death.							
22b SIGNATURE <b>Chamnes Sahakyan</b>		DEGREE <b>MD</b>	ATTENDING PHYS <b>XX</b>	MED DIRECTOR <b>XX</b>	STAFF PHYS <b>XX</b>	22c DATE SIGNED <b>Nov. 26, 1968</b>	
22d PHYSICIAN'S NAME (Type) <b>Chamnes Sahakyan, M. D.</b>		22e. ADDRESS <b>6001 Landover Rd., Cheverly, Md. 20785</b>					
23a BURIAL, CREMATON, REMOVAL (Specify) <b>Burial</b>		23b DATE <b>Nov 30, 1968</b>	23c NAME OF CEMETERY OR CREMATORIUM <b>Ft Lincoln Cemetery</b>	23d LOCATION (City or Town) <b>Colmar Manor</b>	(County) <b>Pro Geo</b>	(State) <b>N.J.</b>	
24. FUNERAL DIRECTOR		ADDRESS <b>F. Gasch's Sons Hyattsville, Md.</b>		25a. REC'D BY REGISTRAR DATE <b>DEC 2 1968</b>	25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		



MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
**CERTIFICATE OF DEATH**

16439

16453

**10 HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

**Page 4 may be retained by the hospital or attending physician.**  
**10 FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper pages 1 and 2 and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print)		First <i>Whitley</i>	Middle <i>G</i>	Last <i>Thayer</i>	20. DATE OF DEATH Month <i>11</i>	Day <i>11</i>	Year <i>68</i>	2b. HOUR <i>2400</i>			
3. SEX <i>Male</i>		4. RACE <i>white</i>	5. DATE OF BIRTH <i>5-21-03</i>		6. AGE (In years last birthday) <i>65 yrs.</i>		IF UNDER 1 YEAR MONTHS <i>65</i>		IF UNDER 24 HRS HOURS <i>0</i>		
7a. BIRTHPLACE (State or foreign country) <i>Maryland</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED		9. COUNTY OF DEATH <i>P.G.</i>					
10. CITY OR TOWN OF DEATH <i>Clinton</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Clinton Hospital</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>certified Auto Mechanic</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Auto</i>					
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE <i>MD</i>		13b. COUNTY <i>P.G.</i>		13c. CITY OR TOWN <i>Clinton</i>		13d. INSIDE CITY LIMIT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		13e. STREET AND NUMBER <i>6749 Colonial Ln.</i>			
14. FATHER'S NAME First <i>George</i>		Middle <i>Thayer</i>	Last	15. MOTHER'S MAIDEN NAME First <i>Eliza</i>		Middle <i>J.</i>	Last <i>Smith</i>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <i>Yes</i>		16b. SOCIAL SECURITY NO <i>(If yes give war or dates of service)</i>		17. INFORMANT <i>Madalin J. Thayer</i>		Address					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)		MYOCARDIAL INFARCTION				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>30 min</i>					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause <i>109</i>		DUE TO, OR AS A CONSEQUENCE OF (b) <i>HTLV i ANGINA</i>				10 years					
(c) <i>two years Dr. von Schwartz</i>		<i>prolonged die.</i>									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)											
4001		Obesity									
19a. DATE OF OPERATION <i>4/1/68</i>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner) <i>While at work</i>		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) <i>Office Building, etc.</i>		21f. LOCATION Street or R.F.D. No		City or Town		County	State		
22o. I certify that (I) (this hospital) attended the deceased from <i>11/1/68</i> , to <i>11/1/68</i> , that (I) (we) last saw the deceased alive on <i>10/28/68</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>Rosemarie</i>		DEGREE <i>PHYS</i>	ATTENDING PHYS	<input type="checkbox"/>	MED DIRECTOR	<input type="checkbox"/>	STAFF PHYS	<input checked="" type="checkbox"/>	22c. DATE SIGNED <i>11/11/68</i>		
22d. PHYSICIAN'S NAME (Type) <i>ROSE. W. MERKLE, M.D.</i>		22e. ADDRESS <i>CLINTON, MARYLAND</i>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>11-11-68</i>		23c. NAME OF CEMETERY OR CREMATORIUM <i>Cedar Hill Cemetery</i>		23d. LOCATION (City or Town) <i>Suitland</i>		(County) <i>Pr. Geo.</i>	(State) <i>Md.</i>		
24. FUNERAL DIRECTOR <i>Wilhelm</i>		ADDRESS <i>Suitland Md.</i>		25a. REC'D BY REGISTRAR <i>NOV 18 1968</i>		25b. REGISTRAR'S SIGNATURE <i>George J. Dease</i>					



Item 7a PGGenHosp.Phone, MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16454

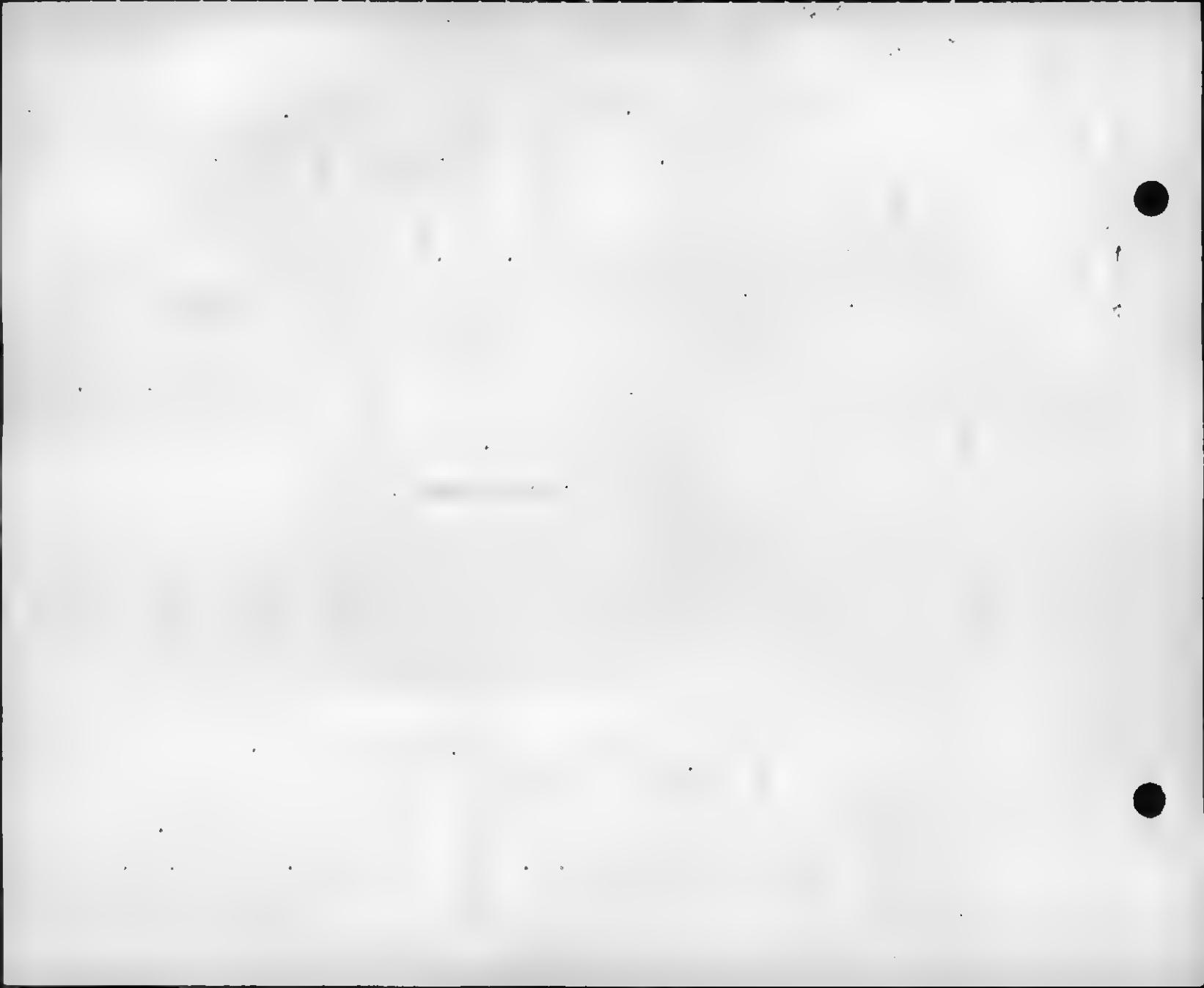
CERTIFICATE OF DEATH

1. DECEASED NAME (Type or print)	First <b>Debbie</b>	Middle <b>A.</b>	Last <b>Thomas</b>	20. DATE OF DEATH Month <b>Nov.</b>	Day <b>30</b>	Year <b>68</b>	2b. HOUR <b>5:18PM</b>				
3. SEX <b>Female</b>	4. RACE <b>Cauc.</b>	5. DATE OF BIRTH <b>09-27-68</b>			6. AGE (In years last birthday) <b>2 yrs.</b>	IF UNDER 1 YEAR <b>2</b>	IF UNDER 24 HRS. MONTHS <b>3</b>	DAYS <b>-</b>	HOURS <b>-</b>	MIN. <b>-</b>	
7a. BIRTHPLACE (State or foreign country) <b>Md Va.</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH <b>Prince Georges</b>								
10. CITY OR TOWN OF DEATH <b>Cheverly</b>	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Prince Georges Gen. Hosp.</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>none</b>	12b. KIND OF BUSINESS OR INDUSTRY						
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Md.</b>	13c. CITY OR TOWN <b>Prince Georges</b>	13d. INSIDE CITY LIMITS? <b>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></b>	13e. STREET AND NUMBER <b>702 Chaney Drive</b>								
14. FATHER'S NAME First <b>Lewis G</b>	Middle <b>Thomas</b>	Last	15. MOTHER'S MAIDEN NAME First <b>Louise Raines</b>								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <b>—</b>	16b. SOCIAL SECURITY NO. <b>---</b>	17. INFORMANT <b>Lewis G Thomas</b>				Address <b>Takoma Park, Md.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Respiratory Arrest, Acute</b> <b>4X0 X</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), (b) <b>Secondary Bronchopneumonia, Left Lung</b> stating the underlying cause lost. (c)						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
MEDICAL CERTIFICATION		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			Yes						
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING OR CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b.)									
21d. INJURY OCCURRED While at work Not while at work	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. <b>—</b>	City or Town	County	State						
22a. I certify that (I) <b>(initials)</b> attended the deceased from <b>Nov. 30, 1968</b> , to <b>Nov. 30, 1968</b> , that (I) <b>(initials)</b> last saw the deceased alive on <b>Nov. 30, 1968</b> , and that in my <b>(initials)</b> opinion death occurred on the date and hour and from the causes stated above, (I) <b>(initials)</b> did <b>(initials)</b> view the body after death.											
22b. SIGNATURE <b>Bertha Van Gelderen</b>	DEGREE <b>M. D.</b>	ATTENDING PHYS. <b>x</b>	MED DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	22c. DATE SIGNED <b>Dec. 2, 1968</b>						
22d. PHYSICIAN'S NAME (Type) <b>Bertha Van Gelderen, M. D.</b>	22e. ADDRESS <b>3001 Cheverly Ave., Cheverly, Md. 20785</b>										
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>Dec 4, 1968</b>	23c. NAME OF CEMETERY OR CREMATORIAL <b>Zion Church Cemetery</b>	23d. LOCATION (City or Town) <b>Spotsylvania County</b>	(County) <b>Spotsylvania County</b>	(State) <b>Va</b>						
24. FUNERAL DIRECTOR <b>F. Gasch's Sons</b>	ADDRESS <b>Hyattsville, Md.</b>	25a. REC'D BY REGISTRAR DATE <b>DEC 4 1968</b>	25b. REGISTRAR'S SIGNATURE <b>Charles J. Gasch</b>								

10. **HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

TO **FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16441

Item #3a, Film GL07 12/9/68 km

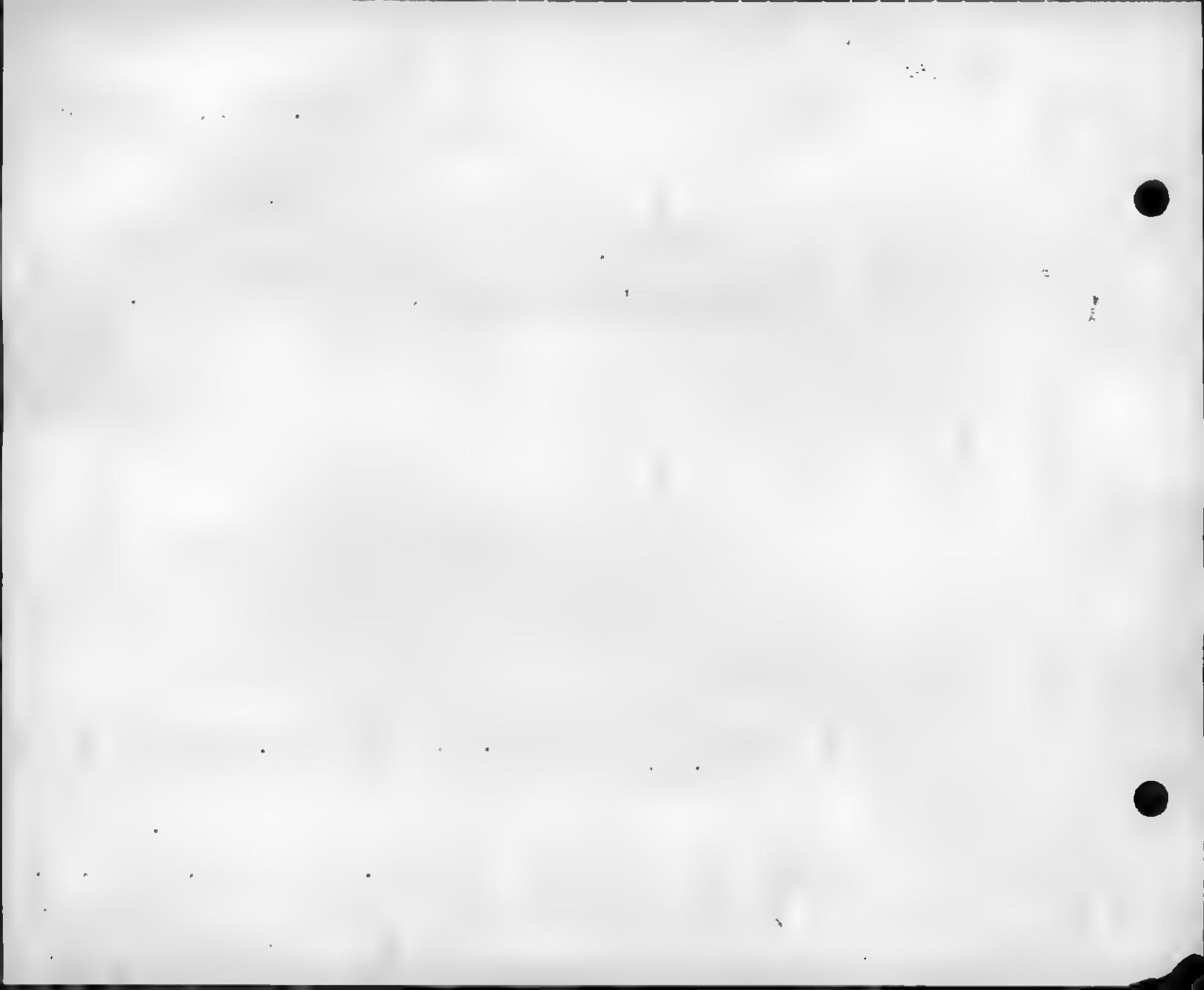
## CERTIFICATE OF DEATH

16450

**10 HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.  
**Page 4 may be retained by the hospital or attending physician.**

**10 FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 DECEASED NAME (Type or print)	First James	Middle Thomas	Last	2a DATE OF DEATH Month Nov. Day 25, Year 1968	2b HOUR 3:10PM
3 SEX Male	4. RACE Negroid	S. DATE OF BIRTH 6-1875	6. AGE (in years last birthday) 93 yrs	F. UNDER 1 YEAR MONTHS DAYS	I. F. UNDER 24 HRS. HOURS MIN
7a BIRTHPLACE (State or foreign country) Md	7b CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Prince George's	Md.	
10 CITY OR TOWN OF DEATH Cheverly	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Prince Geo. Gen'l Hospital	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Farmer	12b KIND OF BUSINESS OR INDUSTRY On Farm		
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Maryland	13b. COUNTY Prince George's	13c. CITY OR TOWN Mitchellsille	13d. NSIDE CTY LIM TS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e STREET AND NUMBER Route #2, Box 27.	
14 FATHER'S NAME First James Thomas	Middle	Last	15 MOTHER'S MAIDEN NAME First Mary West	Middle	Last
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No	16b SOCIAL SECURITY NO —	17 INFORMANT John Thomas Bowie Md	Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 011.9 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
(b) DUE TO, OR AS A CONSEQUENCE OF					
(c)					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)		
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME FARM STREET FACTORY, OFFICE BUILDING, ETC.)	21f LOCATION Street or R.F.D. No	City or Town	County State
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from Nov. 10, 1968, to Nov. 25, 1968, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on Nov. 25, 1968, and that <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) <input checked="" type="checkbox"/> (did not) view the body after death.					
22b. SIGNATURE Arnold G. Brody		DEGREE ATTENDING PHYS	MED DIRECTOR <input checked="" type="checkbox"/>	STAFF PHYS <input checked="" type="checkbox"/>	22c. DATE SIGNED Nov. 25, 1968
22d. PHYSICIAN'S NAME (Type) Dr. Arnold G. Brody		22e. ADDRESS Prince Geo. Gen'l Hospital, Cheverly, Md.			
23a. BURIAL CREMATION, B-REMOVAL (Specify) 11-30-68		23c. NAME OF CEMETERY OR CREMATORIAL Harmony		23d. LOCATION (City or Town) Highland Park Md	(County) (State)
24. FUNERAL DIRECTOR H. S. Washington 4925 Dundee St		ADDRESS DATE DEC 2 1968		25a. REG'D BY REGISTRAR Charles Judge	
				25b. REGISTRAR'S SIGNATURE	



FOR STATE  
HEALTH DEPT.

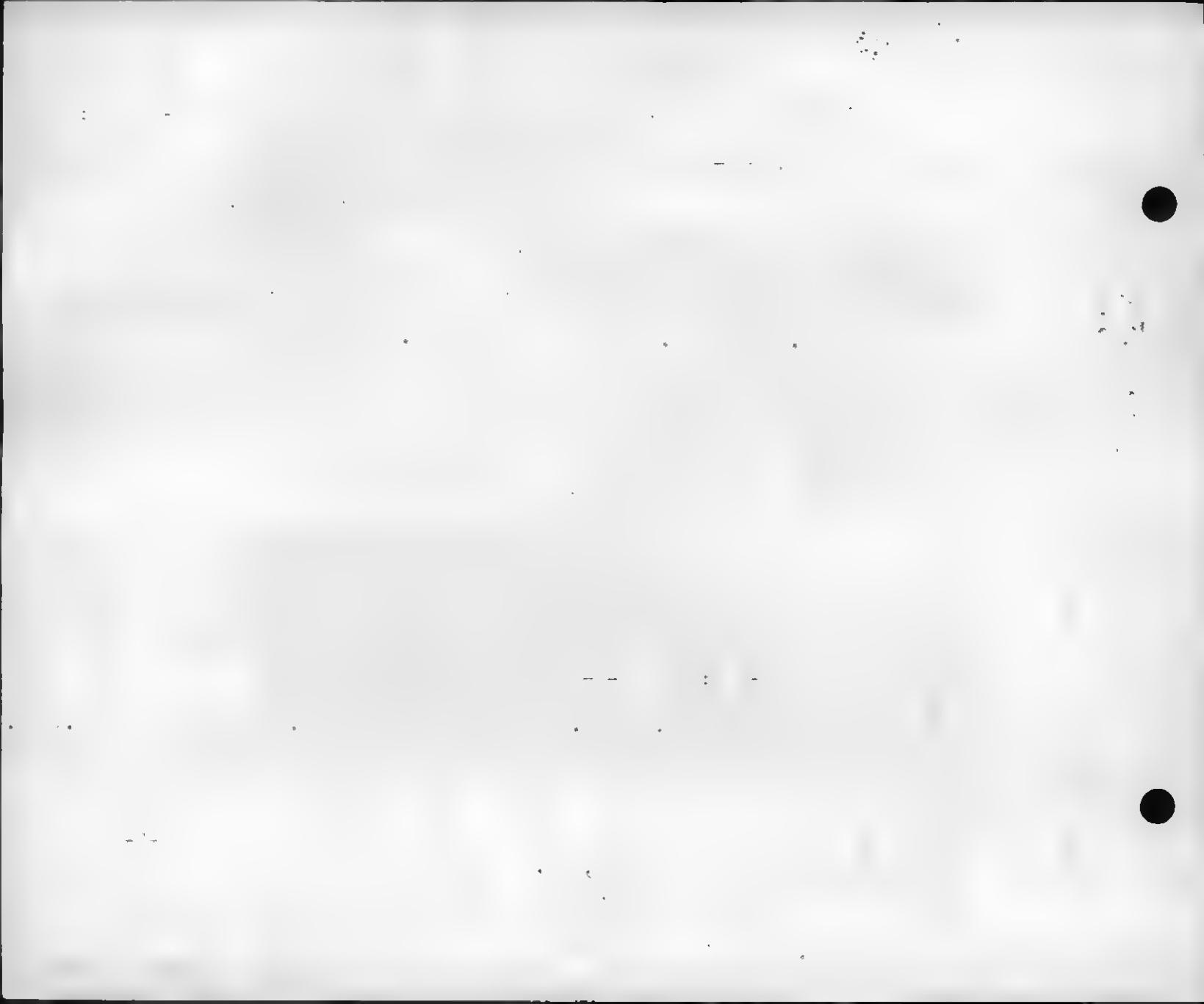
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 2. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form M-1, Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1645..

1. DECEASED NAME (Type or Print)		First <b>William</b>	Middle <b>J</b>	Last <b>Thomas</b>	Jr. <b>.</b>	2a DATE KNOWN OF EST. DEATH MATED <input checked="" type="checkbox"/>	Month <b>11</b>	Day <b>6</b>	Year <b>1968</b>	2b HOUR <b>12:45am M</b>
3 SEX <b>Male</b>	4 RACE <b>White</b>	5 DATE OF BIRTH <b>11-17-1946</b>	6 AGE (in years last birthday) <b>21</b>	7 IF UNDER 1 YEAR MONTHS <b>YRS</b>	8 IF UNDER 24 HRS MONTHS <b>0</b>	9 DATE PRONOUNCED DEAD Month <b>6</b>	Day <b>6</b>	Year <b>1968</b>	10 HOUR <b>3:00am M</b>	
7a BIRTHPLACE (State or foreign country) <b>DC</b>		7b CITIZEN OF WHAT COUNTRY? <b>USA</b>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH <b>Prince George's</b>				
10 CITY OR TOWN OF DEATH <b>Cheverly</b>		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Prince George Hospital</b>		12a USUAL OCCUPATION (Kind of work done during working life, even if retired) <b>Mechanic</b>		12b KIND OF BUSINESS OR INDUSTRY <b>Auto</b>				
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) <b>Maryland</b>		13c CITY OR TOWN <b>Prince George's Forestville</b>		13d INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		13e STREET AND NUMBER <b>209 Pine Grove Drive</b>				
14 FATHER'S NAME First <b>William J.</b>		Middle <b>Thomas Sr.</b>	Last	15. MOTHER'S MAIDEN NAME First <b>Mary G. Barney</b>						
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16b SOCIAL SECURITY NO. <b>Unknown</b>		17. INFORMANT (Father) <b>William J. Thomas Sr., Same as # 13</b>		ADDRESS				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										
PART I. DEATH WAS CAUSED BY-										
IMMEDIATE CAUSE (a) <b>Bilateral hemothorax</b>										
DUE TO, OR AS A CONSEQUENCE OF <b>Multiple rib fractures</b>										
Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying cause</u> last.										
(b) <b>From trauma - auto accident</b>										
DUE TO, OR AS A CONSEQUENCE OF										
(c)										
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		19c. AUTOPSY?						
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
21a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b TIME OF INJURY Month, Day, Year HOUR A.M. <b>11-6-68 2:40am</b>		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b)						
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.) <b>Suitland Road, 125ft. west of Meadow View Dr., Prince George Co., Md.</b>		21f LOCATION Street or R.F.D. No City or Town County State						
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>										
ACTUAL SIGNATURE <i>John Kehoe</i>		MD		CHIEF MEDICAL EXAMINER <input type="checkbox"/>						
EXAMINER'S NAME (Type) <b>John Kehoe MD Riverdale, Md.</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>						
23a BURIAL, CREMATION REMOVAL (SPECIFY) <b>BURIAL</b>		23b DATE <b>11-9-68</b>		23c NAME OF CEMETERY OR CREMATORIAL <b>Washington National Cem.</b>		23d LOCATION (City or Town) <b>Suitland, PG Maryland</b>		(County) (State)		
24 FUNERAL DIRECTOR <b>Wilhelm Funeral Home</b>		ADDRESS <b>4308 Suitland Rd. SE, Suitland, Maryland</b>		25a REC'D BY REGISTRAR <b>Charles Jones</b>		25b REGISTRAR'S SIGNATURE <b>Charles Jones</b>				
DATE NOV 18 1968										



## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16457

## CERTIFICATE OF DEATH

**10 HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

**Page 4 may be retained by the hospital or attending physician.**

**10 FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completed in full by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

*Attending Physician and Hospital Signature*

1. DECEASED NAME (Type or print)			First Thomas	Middle A.	Last Thornhill	2a. DATE OF DEATH Month Nov. Day 21, Year 1968	2b. HOUR 5:15AM					
3 SEX <b>Male</b>		4 RACE <b>Caucasian</b>		5 DATE OF BIRTH <b>May 2, 1968</b>		6. AGE (in years last birthday) <b>6 yrs.</b>		7. UNDER 1 YEAR MONTHS <b>6</b>		IF UNDER 24 HRS HOURS <b>—</b>		
7a. BIRTHPLACE (State or foreign country) <b>Texas</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Prince George's</b>						
10. CITY OR TOWN OF DEATH <b>Cheverly</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Prince Geo. Gen'l Hospital</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>—</b>			12b. KIND OF BUSINESS OR INDUSTRY			
13a. U.S.A. RESIDENCE (Where deceased lived, if institution Resdence before admission) STATE <b>Maryland</b>			13c. CITY OR TOWN <b>Prince George's Hyattsville</b>			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>5833 33rd Place</b>				
14. FATHER'S NAME First Thomas			Middle J.	Last Thornhill	15. MOTHER'S MAIDEN NAME First Isabella		Middle Santini	Last —				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <b>—</b>			16b. SOCIAL SECURITY NO. —			17. INFORMANT Thomas J. Thornhill			Address <b>Hyattsville, Md.</b>			
18. CAUSE OF DEATH (Enter only one cause per the law (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Respiratory failure</b>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
1467 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last			DUE TO, OR AS A CONSEQUENCE OF (b) <b>Congenital heart disease (Tricuspid Arrearsus)</b>			DUE TO, OR AS A CONSEQUENCE OF (c) <b>Respiratory weakness: Pulmonary; Lungs</b>			<i>Partial Cleft palate</i>			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 <i>—</i>												
19a. MEDICAL CERTIFICATION DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b)								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County		State		
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to Nov. 21, 1968, that (I) (we) last saw the deceased alive on Nov. 21, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) <input checked="" type="checkbox"/> (did not) view the body after death												
22b. SIGNATURE <i>—</i>			22c. DEGREE ATTENDING PHYS <input checked="" type="checkbox"/>			MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>			DATE SIGNED <b>Nov. 21, 1968</b>			
22d. PHYSICIAN'S NAME (Type) <b>Bernardo Alvarado, M.D.</b>			22e. ADDRESS <b>6201 Riverdale Rd., Riverdale, Md. 20840</b>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>11/23/68</b>		23c. NAME OF CEMETERY OR Crematory <b>Mt Olivet Cemetery</b>		23d. LOCATION (City or Town) <b>Washington D. C.</b>		(County)		(State)		
24. FUNERA. DIRECTOR <b>F. Gasch's Sons Hyattsville, Md.</b>			ADDRESS <b>—</b>			25a. RECD BY REGISTRAR DATE <b>NOV 25 1968</b>		26. REGISTRAR'S SIGNATURE <i>Judge</i>				



FOR STATE  
HEALTH DEPT.

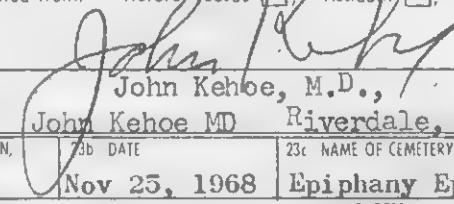
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word pending in pen in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

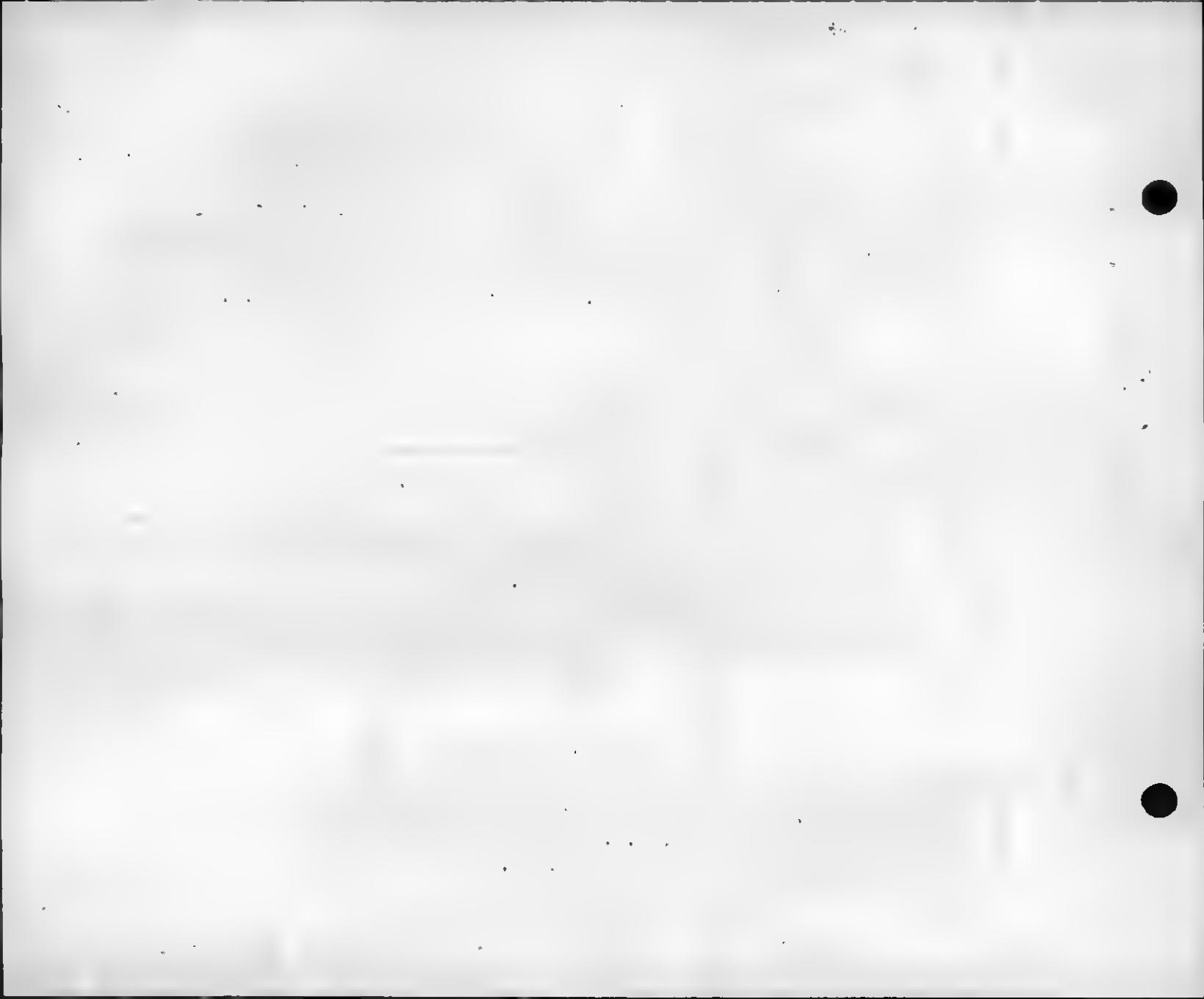
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

16445 1545

1. DECEASED NAME (Type or Print)			First	Middle	Last	2a. DATE KNOWN OF ESTI- DEATH MATED	Month	Day	Year	2b. HOUR	
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (In years last <input type="text"/> month /45 YRS)	IF UNDER 1 YEAR MONTHS	IF UNDER 24 HRS DAYS	MIN	2c. DATE PRONOUNCED DEAD	Month	Day	Year	2d. HOUR
Female	White	4-16-1923					11-22-68	11	22	68 19	1:10 A.M.
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/>	NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/>	DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH			
Md		U.S.A.						Prince George's			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY		
Riverdale			Island Hospital			Clerk			Department store		
13a. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) STATE			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?			13e. STREET AND NUMBER		
Maryland			Prince George's Mt. Rainier			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			3513 R.I. Avenue		
14. FATHER'S NAME			First	Middle	Last	15. MOTHER'S MAIDEN NAME	First	Middle	Last		
			Albert B Ridgeway			Susie A Vermillion					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> No			16b. SOCIAL SECURITY NO (If yes give war or dates of service) 218 24 0482			17. INFORMANT			ADDRESS		
						Oscar J. Trainum			Mt Rainier, Md.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Heart failure											
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) (b) Arteriosclerotic heart disease											
stating the underlying cause due to, or as a consequence of lost. 4200 (c)											
Unknown											
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Min.											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Diabetes mellitus-known over 3 yrs.											
19a. DATE OF OPERAT ON			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY?					
						YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE 			John Kehoe, M.D., John Kehoe MD Riverdale, Md.			CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			22b. DATE SIGNED 11-22-68		
EXAMINER'S NAME (Type)									ADDRESS (Street, city, town, or county)		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE Nov 25, 1968			23c. NAME OF CEMETERY OR XPOSITORY Epiphany Episcopal Church			23d. LOCAT ON (City or Town) (County) (State) Forestville Pro Geo Md.		
24. FUNERAL DIRECTOR F. Gaseh's Sons			ADDRESS Hyattsville, Md.			25a. REC'D BY REG STRAR NOV 27 1968			25b. REG STRAR'S SIGNATURE Charles Judge		
VR A15ME (5) TOM REV 1 68											



MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

**10 HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.  
**10 FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Then please remove carbon papers. Then please remove carbon papers.

1 DECEASED NAME (Type or print)		First <b>George</b>	Middle	Lost <b>Trower</b>	2a DATE OF DEATH Month <b>November 9, 1968</b>	2b HOUR 1:05AM				
3 SEX <b>Male</b>	4 RACE <b>Colored</b>	S DATE OF BIRTH <b>6/29/05</b>	6 AGE (in years last birthday) <b>63</b>	F JNOER 1 YEAR YRS <b>1</b>	IF UNDER 24 HRS MONTHS <b>0</b>	DAYS <b>0</b>	HOURS <b>0</b>	MIN <b>0</b>		
7a BIRTHPLACE (State or foreign country) <b>Md.</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9 COUNTY OF DEATH <b>Prince George's</b>							
10 CITY OR TOWN OF DEATH <b>Cheverly</b>	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Prince George's Gen. Hosp.</b>			12a USUAL OCCUPATION (Kind of work done during time of working life even if retired) <b>Painter</b>			12b KIND OF BUSINESS OR INDUSTRY <b>Md.</b>			
13a U.S.A. RESIDENCE (Where deceased lived, if institution residence before admission) STATE <b>Maryland</b>	13b COUNTY <b>Prince George's</b>	13c CITY OR TOWN <b>Seat</b>	13d INSIDE CITY LIMITS <b>YES</b>	13e STREET AND NUMBER <b>6704 F St.</b>						
4 FATHER'S NAME <b>Matthew Trower</b>	First	Middle	Lost	15 MOTHER'S MAIDEN NAME First <b>Betty</b>	Middle	Last				
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown <b>No</b>	16b SOCIAL SECURITY NO <b>—</b>	17 INFORMANT <b>Flora Horrood</b>	Address							
18 CAUSE OF DEATH (Enter on y one cause per line for (a), (b) and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Bronchopneumonia (organism undetermined)</b>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
2504 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost							years			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>Idiopathic Epilepsy</b>										
19a MEDICAL CERTIFICATION <b>None</b>	19b DATE OF OPERATION	19c CONDIT ON FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? <b>YES</b>	20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>Yes</b>						
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>	21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b)							
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY OFFICE BUILDING, ETC)	21f LOCATION Street or R.F.D. No.	City or Town	County	State				
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>11/3</b> , 1968, to <b>Nov. 9</b> , 1968, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>November 9, 1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) <input checked="" type="checkbox"/> did <input checked="" type="checkbox"/> not view the body after death.										
22b. SIGNATURE <b>Fidel J. Quintana</b>		DEGREE <b>ATTENDING PHYS</b>	<input checked="" type="checkbox"/> MED DIRECTOR	<input type="checkbox"/> STAFF PHYS	22c DATE SIGNED <b>11-9-68</b>					
22d PHYSICIAN'S NAME (Type) <b>FIDEL J. QUINTANA</b>		22e ADDRESS <b>87-5 FIRST AVE, S. SPRING, MD.</b>								
23a BURIAL/CREMATION, REMOVAL (Specify)	23b DATE <b>11-15-68</b>	23c NAME OF CEMETERY OR CREMATORIAL <b>Harmony</b>	23d LOCATION (City or Town) <b>Highland Park Md</b>		(County) <b>Charles</b>		(State)			
24 FUNERAL DIRECTOR <b>H.S. Washington</b>	ADDRESS <b>4925 Dom Goe NE</b>	25d REC'D BY REGISTRAR <b>NOV 14 1968</b>	25b REGISTRAR'S SIGNATURE <b>Charles Judge</b>							



FOR STATE  
HEALTH DEPT.

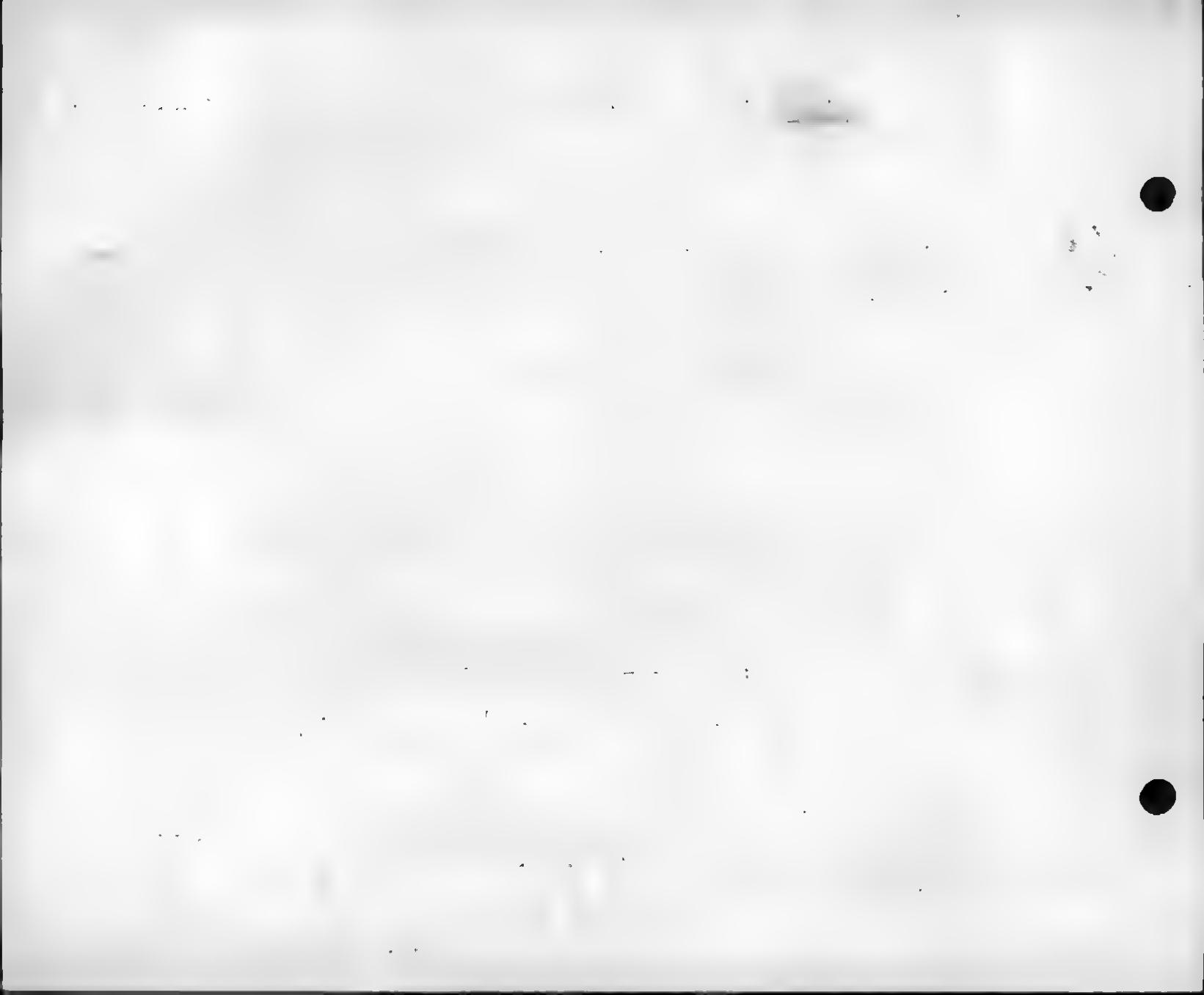
**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. Any delay necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

**MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201**

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. DECEASED NAME (Type or Print)			First	Middle	Lost	2a DATE KNOWN OF ESTI- DEATH MATED	Month	Day	Year	2b HOUR	
Unidentified			Negro	Male		11-4-68	1966	03pm			
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (in years last birthday) YRS.	F UNDER 1 YEAR MONTHS	IF UNDER 24 HRS HOURS						
Male	Negro	unknown		Days	Min						
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			2c DATE PRONOUNCED DEAD Month Day Year		
Cheverly		Prince George Hospital		Prince George's			68 1966 55pm		2d HOUR		
0. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b KIND OF BUSINESS OR INDUSTRY		
unknown			Prince George Hospital			unknown			Md		
13a USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission)		13b COUNTY		13c CITY OR TOWN		13d. INSIDE CITY LIMITS?	13e STREET AND NUMBER				
STATE unknown		unknown		unknown		YES <input type="checkbox"/> NO <input type="checkbox"/>	unknown				
14. FATHER'S NAME		First	Middle	Lost	15. MOTHER'S MAIDEN NAME		First	Middle	Lost		
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b SOCIAL SECURITY NO		17. INFORMANT		ADDRESS					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Laceration of brain</u> Conditions, if any, which gave rise to immediate cause (a) _____ stating the underlying cause last. _____ (b) _____ DUE TO, OR AS A CONSEQUENCE OF Trauma - struck by car (c) _____ PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>11-4</u>											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY?					
21a EXTERNA. CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH:			21b TIME OF INJURY Month, Day, Year HOUR A.M. 6:00pm 11-4-1968			21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21d INJURY OCCURRED AT HOME <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e PLACE OF INJURY (At home, farm, street, factory, office, bus stop, etc.) Old Fort Road, Prince George's County, Maryland			21f LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											22b DATE SIGNED
<u>John Kehoe</u> M.D.											11-7-68
ACTUAL SIGNATURE		EXAMINER'S NAME (Type)		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		ADDRESS (Street, city town, or county)	
John Kehoe MD		Riverdale, Md.									
23a BURIAL (CREMATION REMOVAL) (Specify)		23b DATE		23c NAME OF CEMETERY OR CREMATORIAL ADDRESS		23d LOCATION (City or Town) (County) (State)		23e REC'D BY REGISTRAR		23f REGISTRAR'S SIGNATURE	
11-26 '68		11-26 '68		U.S. Naval Inst. School		Baltimore, Md.		NOV 29 1968		Charles Judge	
24. FUNERAL DIRECTOR											



MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

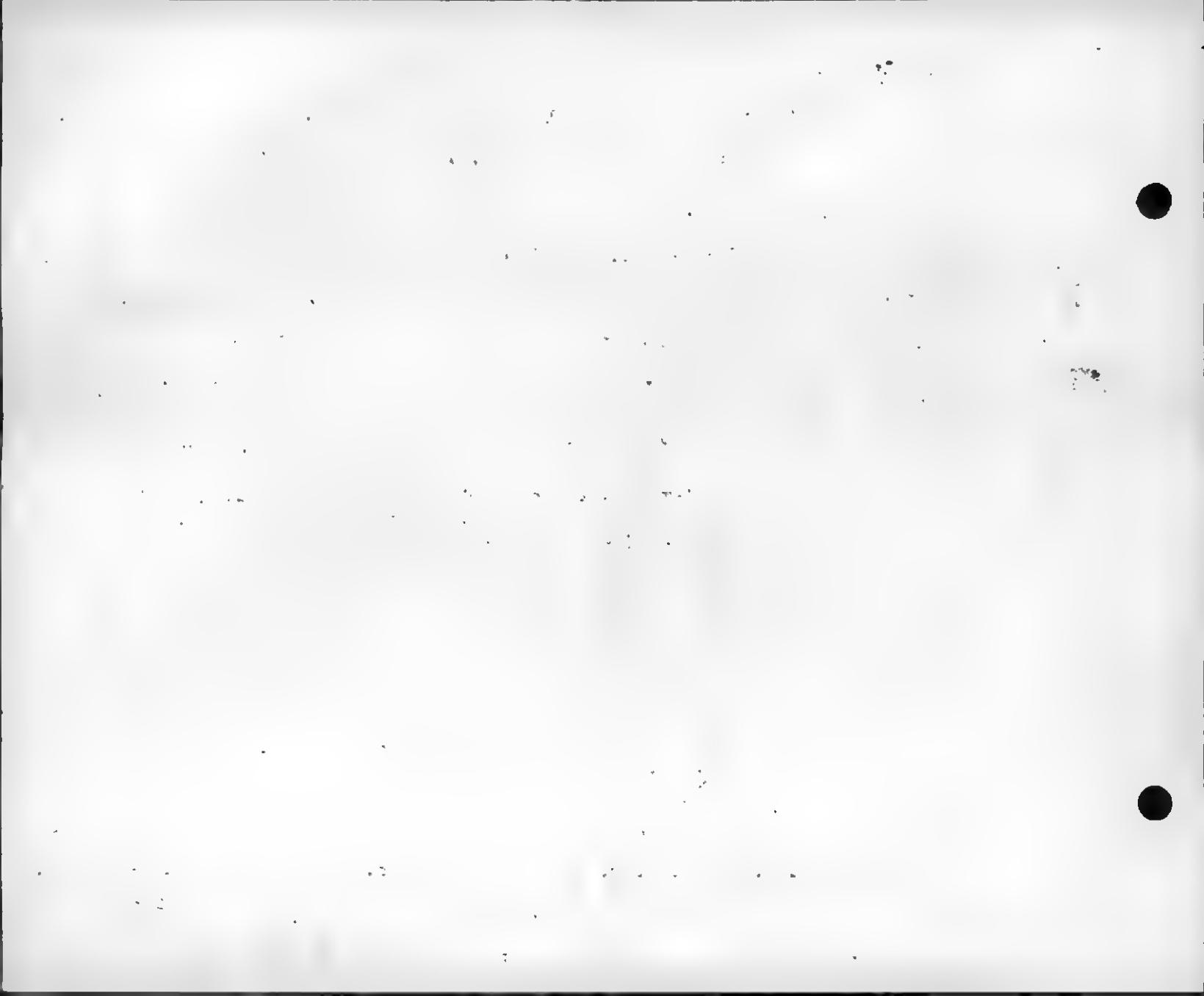
1647

1648

**10 HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.  
 Page 4 may be retained by the hospital or attending physician.

**10 FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper pages 1 and 2 and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print)				First	Middle	Last	2a. DATE OF DEATH Month Nov. 17, 1968 Year	2b. HOUR 11:28 PM		
3. SEX <b>Female</b>		4. RACE <b>Caucasian</b>		5. DATE OF BIRTH <b>4/2/02</b>			6. AGE (In years last birthday) <b>66</b>	IF UNDER 1 YEAR MONTHS <b>YRS</b>	IF UNDER 24 HRS HOURS MIN	
7a. BIRTHPLACE (State or foreign country) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED			9. COUNTY OF DEATH <b>Prince George's</b>			
10. CITY OR TOWN OF DEATH <b>Cheverly</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Prince Geo. Gen'l Hospital</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Housewife</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>At Home</b>		
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE <b>Maryland</b>		13b. COUNTY <b>Prince George's</b>		13c. CITY OR TOWN <b>Landover</b>		13d. INSIDE CITY, J.M.T? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	13e. STREET AND NUMBER <b>3410 Dodge Park Road</b>			
14. FATHER'S NAME First <b>James</b>		Middle <b>w. w</b>	Last <b>America</b>	15. MOTHER'S MAIDEN NAME First <b>Fannie E. Fillius</b>			Middle	Last		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown? <b>No</b>		16b. SOCIAL SECURITY NO <b>577-24-3918</b>		17. INFORMANT <b>Mrs Carolyn F. Heath</b>			Address <b>3410 Dodge Park Rd</b> <b>Landover, Md.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) <b>PART 1 DEATH WAS CAUSED BY</b> <b>IMMEDIATE CAUSE (a)</b> <b>Acute thrombotic occlusion of left coronary artery.</b> <b>DUE TO, OR AS A CONSEQUENCE OF</b> <b>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause</b> <b>lost</b> <b>(b)</b> <b>Arteriosclerotic heart disease, severe, with old myocardial infarction.</b> <b>(c)</b> <b>Congestive heart failure.</b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>4201</b> <b>Diabetes Mellitus.</b>										
19a. DATE OF OPERATION <b>4201</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>Yes</b>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> or work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County	State	
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>Nov. 17, 1968</b> , to <b>Nov. 17, 1968</b> , that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on <b>Nov. 17, 1968</b> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) did <input checked="" type="checkbox"/> (not) view the body after death.										
22b. SIGNATURE <b>Arnold G. Brody</b>		DEGREE <b>M.D.</b>	ATTENDING PHYS <input type="checkbox"/>	MED DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input checked="" type="checkbox"/>	22c. DATE SIGNED <b>Nov. 18, 1968</b>				
22d. PHYSICIAN'S NAME (Type) <b>Arnold G. Brody, M. D.</b>		22e. ADDRESS <b>Prince Geo. Gen'l Hospital, Cheverly, Md.</b>								
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE <b>Nov. 21, 1968</b>		23c. NAME OF CEMETERY OR CREMATORIAL <b>Adoration Chapel</b>			23d. LOCATION (City or Town) (County) <b>Seat Pleasant, Md.</b> (State)			
24. FUNERAL DIRECTOR <b>W. W. CHAMBERS CO</b>		ADDRESS <b>517 111ST ST SE Wash DC.</b>		25a. REC'D. BY REGISTRAR DATE <b>NOV 26 1968</b>			25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			



MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

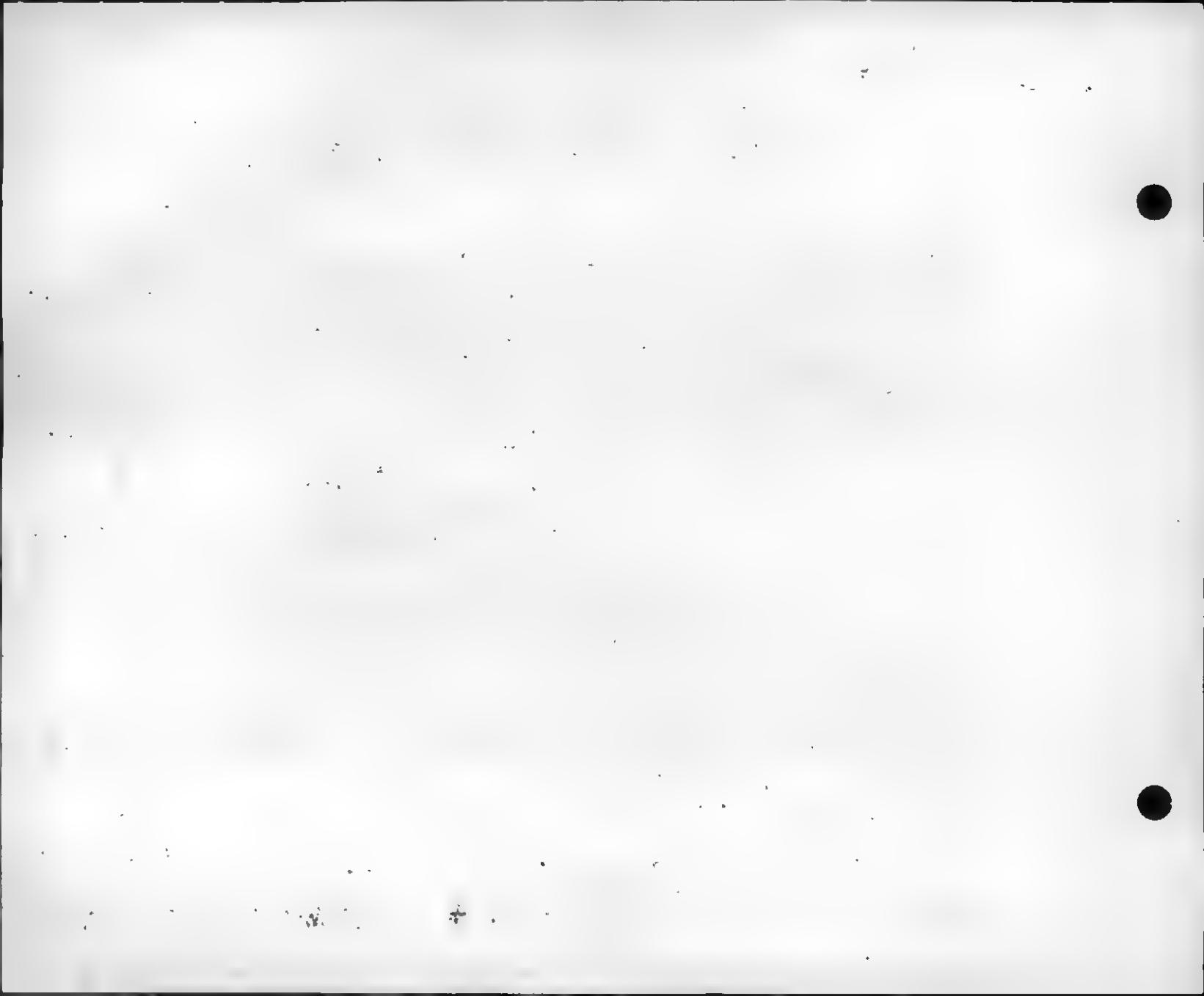
CERTIFICATE OF DEATH

16458

**10 HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

**10 FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician or attending physician, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Please sign and date the original certificate, page 3, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH Month	Day	Year	2b. HOUR 10 <sup>50</sup> AM		
Emmett			H.	Walker		11	6	68			
3 SEX	4. RACE	5. DATE OF BIRTH			6 AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN					
Male	Caucasian	10-14-1892			76 yrs						
7a BIRTHPLACE (State or foreign country)	7b CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>			9. COUNTY OF DEATH						
Virginia	USA	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			Pearce Georges						
10. CITY OR TOWN OF DEATH	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b KIND OF BUSINESS OR INDUSTRY				
Greenbelt	Greenbelt Convalescent Center			Carpenter							
13a USUAL RESIDENCE (Where deceased lived, if institution or Residence before admission)	13b CITY OR TOWN	13c COUNTY	13d INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	13e STREET AND NUMBER							
Mid.	College Park	Md.		10400 Cherry Hill Rd							
14 FATHER'S NAME	First	Middle	Last	15. MOTHER'S MAIDEN NAME	First	Middle	Last				
Bennie			Walker	ELIZABETH.			BELL				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown	16b. SOCIAL SECURITY NO.	17. INFORMANT			Address						
XO	217-03-1974	Mrs Marjorie Walker			10400 Cherry Hill Rd						
PART 1. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))											
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) _____											
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) _____											
DUE TO, OR AS A CONSEQUENCE OF last (c) _____											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(o)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County		State	
22a. I certify that (I) (this hospital) attended the deceased from <u>1/8/65</u> , 19, to <u>11/6/68</u> , 19, that (I) (we) last saw the deceased alive on <u>11/3/68</u> , 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>William B. Gunther</u>		22c. DATE SIGNED <u>11/6/68</u>			22d. PHYSICIAN'S NAME (Type) DR. William B. GUNTHNER		22e. ADDRESS 4917 EDGEWOOD RD COLLEGE PARK MD.				
23a. BURIAL, CREMATION REMOVAL (Specify)		23b. DATE 11-9-1968		23c. NAME OF CEMETERY OR CREMATORIAL FORT LINCOLN CEM			23d. LOCATION (City or Town) OLMAR MANOR		(County) MARYLAND		(State)
24. FUNERAL DIRECTOR W.W. CHAMBERS Co. RIVERDALE, MD		ADDRESS			25a. REC'D BY REGISTRAR NOV 12 1968		25b. REGISTRAR'S SIGNATURE Charles Judge				



FOR STATE  
HEALTH DEPT.Items 18&22a Film 409 MARYLAND STATE DEPARTMENT OF HEALTH  
1-29-69 a.m.s DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

1646..

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 DECEASED NAME (Type or Print)			First	Middle	Last	2a. DATE KNOWN OF ESTI. DEATH MATED	Month	Day	Year	2b. HOUR
			William		Wallace	<input checked="" type="checkbox"/>	11	10	68	10:00am
3 SEX	4. RACE	S. DATE OF BIRTH	6 AGE (in years last birthday)	7 IF UNDER 1 YEAR MONTHS	8 IF UNDER 24 HRS HOURS	2c. DATE PRONOUNCED DEAD Month	10	Year	2d. HOUR	
Male	Negro	Aug. 26, 1934	34 yrs.				68	10:15am		
7a BIRTHPLACE (State or foreign country)	7b CITIZEN OF WHAT COUNTRY?	8 MARRIED WIDOWED	9. COUNTY OF DEATH							
D.C.	U.S.A.	<input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED	Prince George's							
10 CITY OR TOWN OF DEATH	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b KIND OF BUSINESS OR INDUSTRY			
Cheverly	Prince George Hospital				LADDER					
13a U.S.A. RESIDENCE (Where deceased lived, if institution. Residence before 13c CITY OR TOWN	13b. COUNTY		13d. INSIDE CITY LIMITS?	13e STREET AND NUMBER						
Maryland	Prince George's		YES <input type="checkbox"/> NO <input type="checkbox"/>	6420 L Street						
14 FATHER'S NAME	First	Middle	Last	15 MOTHER'S MAIDEN NAME	First	Middle	Last			
Edward Snyder				Ruth E. Nichols						
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	16b SOCIAL SECURITY NO		17 INFORMANT	ADDRESS						
No			Ruth L. Nichols	-6420-L Street Cedar-Hgts Md						
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Cirrhosis of liver										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
571.0 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) and acute alcoholism										
DUE TO, OR AS A CONSEQUENCE OF (c)										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 581.1										
19a DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20 AUTOPSY?
										YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19			21c HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18)				
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f LOCATION Street or R.F.D. No.		City or Town	County	State
22a I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>										22b. DATE SIGNED
<i>John Kehoe</i> ACTUAL SIGNATURE EXAMINER'S NAME (Type) John Kehoe MD Riverdale, Md.										22b. DATE SIGNED 11-11-68
23a. BURIAL/CREMATION REMOVAL. (Specify)		23b. DATE 11-16-68		23c. NAME OF CEMETERY OR CREMATORIAL HARMONY		23d. LOCATION (City or Town) Highland Park Md				(County) (State)
24 FUNERAL DIRECTOR H.S. Washington & Sons		ADDRESS 4925 Penn Ave		25a REC'D BY REGISTRAR NOV 18 1968		25b. REGISTRAR'S SIGNATURE Charles Judge				
VR A15ME (5) 10M REV 1/68										



MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

18238

18450

**10 HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.  
**Page 4** may be retained by the hospital or attending physician.  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3, should be detached for use as the burial/transit permit. Then please remove carbon paper, pages 1 and 2, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print)		First <b>Baby</b>	Middle <b>Girl</b>	Last <b>Watkins</b>	2a. DATE OF DEATH Month <b>Nov.</b>	Day <b>29,</b>	Year <b>1968</b>	2b. HOUR <b>10:55 AM</b>	
3. SEX		4-RACE <b>Female</b>	5. DATE OF BIRTH <b>Nov. 28, 1968</b>		6. AGE (In years last birthday) <b>YRS. 14</b>		IF UNDER 1 YEAR MONTHS <b>45</b>		
7a. BIRTHPLACE (State or foreign country) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <b>XX</b>		9. COUNTY OF DEATH <b>Prince George's</b>		IF UNDER 24 HRS HOURS <b>14</b>	
10. CITY OR TOWN OF DEATH <b>Cheverly</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Prince Geo. Gen'l Hospital</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>Princess Anne Hospital</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Health Care</b>			
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE <b>Maryland</b>		13c. CITY OR TOWN <b>Bladensburg</b>		13d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input type="checkbox"/> NO		13e. STREET AND NUMBER <b>5012 57th Avenue</b>			
14. FATHER'S NAME First <b>Milner</b>		Middle <b>Ross</b>	Last <b>Watkins</b>	15. MOTHER'S MAIDEN NAME First <b>Janice</b>		Middle <b>Lee</b>	Last <b>Erisman</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <b>Yes</b>		16b. SOCIAL SECURITY NO. <b>7769</b>		17. INFORMANT <b>John</b>		Address <b>John</b>			
<p>18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))  <b>Respiratory failure</b>          APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH          PART 1. DEATH WAS CAUSED BY:          IMMEDIATE CAUSE (a) <b>Respiratory failure</b>          DUE TO, OR AS A CONSEQUENCE OF          (b) <b>Asphyxiation</b>          DUE TO, OR AS A CONSEQUENCE OF          (c) <b>Pneumonia. Respiratory</b></p>									
<p>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)</p>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) <b>At home</b>					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) <b>At home</b>		21f. LOCATION Street or R.F.D. No <b>6201 Riverdale Rd.</b>		City or Town <b>Riverdale</b>		County <b>Md.</b>	
<p>22a. I certify that (I) <b>Attended</b> attended the deceased from <b>Nov. 28, 1968</b>, to <b>Nov. 29, 1968</b>, that (I) <b>lost</b> saw the deceased alive on <b>Nov. 29, 1968</b>, and that in (my) <b>opinion</b> death occurred on the date and hour and from the causes stated above, (I) <b>did not</b> view the body after death.</p>									
22b. SIGNATURE <b>Bernardo Alvarado, M.D.</b>		22c. DATE SIGNED <b>Nov. 29, 1968</b>							
22d. PHYSICIAN'S NAME (Type) <b>Bernardo Alvarado, M.D.</b>		22e. ADDRESS <b>6201 Riverdale Rd., Riverdale, Md. 20840</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>12-28-68</b>		23b. DATE <b>12-28-68</b>		23c. NAME OF CEMETERY OR CREMATORIAL <b>Prince George's Gen. Hosp.</b>		23d. LOCATION (City or Town) <b>Cheverly</b>		(County) (State) <b>P.G. Maryland</b>	
24. FUNERAL DIRECTOR <b>Harry W. Penn, Jr., Administrator</b>		ADDRESS		25a. REC'D BY REGISTRAR <b>DEC 26 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			



## MARYLAND STATE DEPARTMENT OF HEALTH

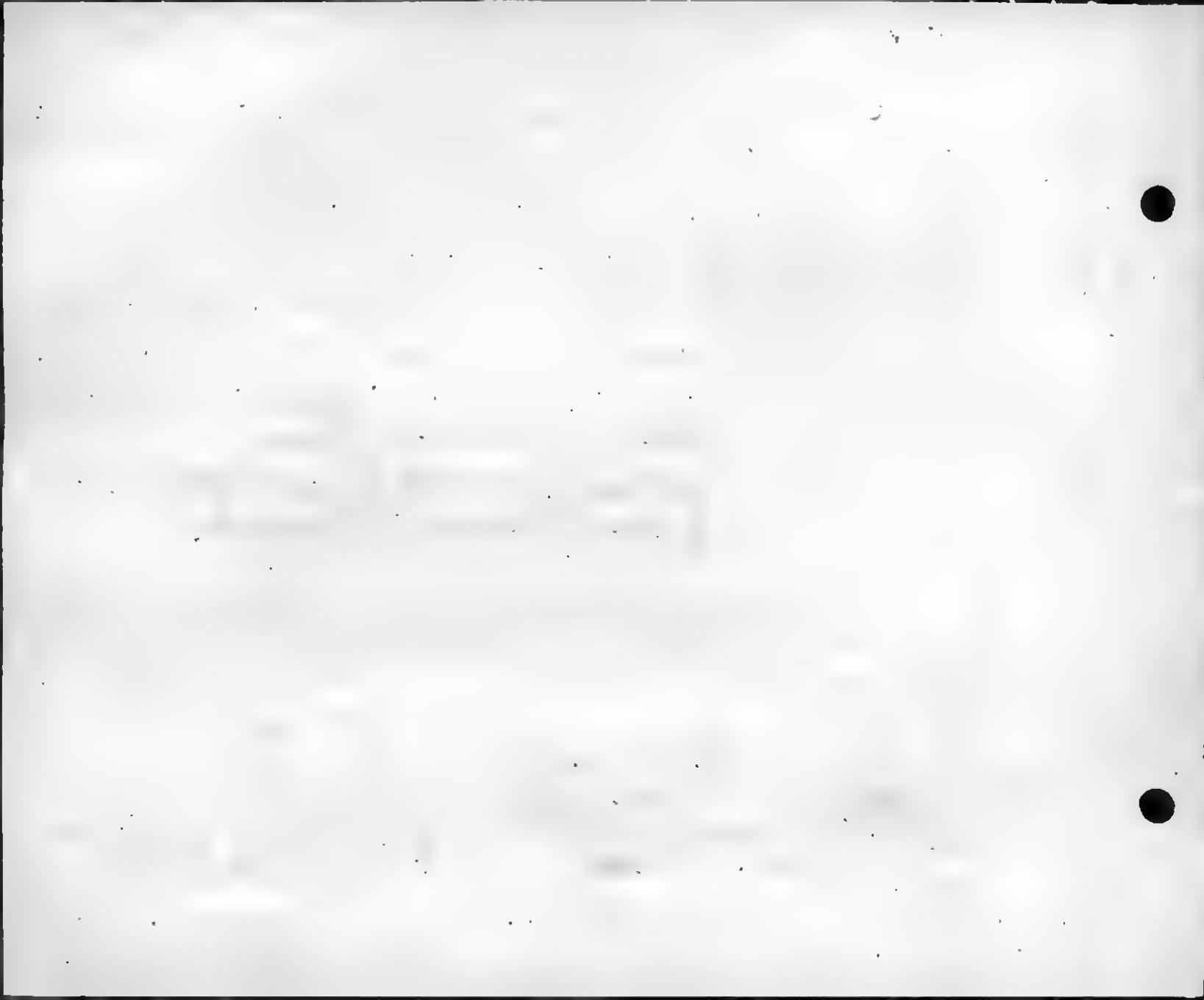
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## CERTIFICATE OF DEATH

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.  
 Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completed in full, fill in box 3, and then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print)	First <b>Catherine</b>	Middle	Last <b>Wenzel</b>	2d. DATE OF DEATH Month <b>November</b>	Day <b>2</b>	Year <b>1968</b>	2d. HOUR <b>3 PM</b>	
3. SEX Female	4 RACE Caucasian	S. DATE OF BIRTH <b>3-4-87</b>	6. AGE (in years at birth) <b>81</b>	IF UNDER 1 YEAR MONTHS <b>0</b>	IF UNDER 24 HRS DAYS <b>0</b>	HOURS <b>00</b>	MIN <b>00</b>	
7a. BIRTHPLACE (State or foreign country) <b>Tennessee</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH <b>Prince Georges County Md.</b>					
10. CITY OR TOWN OF DEATH <b>Riverdale</b>	11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) <b>Leland Memorial Hospital</b>	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>Practicing Physician</b>	12b. KIND OF BUSINESS OR INDUSTRY <b>Medical Record</b>					
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) <b>Virginia</b>	13b. COUNTY <b>Falls Church</b>	13c. CITY OR TOWN <b>Falls Church</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER <b>808 W. Broad Street</b>				
14. FATHER'S NAME First <b>Andrew A</b>	Middle <b>Schatz</b>	15. MOTHER'S MAIDEN NAME First <b>Francis</b>	Address <b>Bierlein</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <b>Yes</b>	16b. SOCIAL SECURITY NO. <b>224-72-3595</b>	17. INFORMANT <b>Joseph A. Wenzel - Medical Records</b>	APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
18. CAUSE OF DEATH (Enter only one cause per line for item (a) and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Bilateral Pneumonia</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), starting the underlying cause lost. <b>Hypertension/arteriosclerosis and vascular disease</b> (b) <b>Cerebral Thrombosis &amp; (B) Aneurysm</b> DUE TO, OR AS A CONSEQUENCE OF								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>443</b>								
19a. DATE OF OPERATION <b>10/04/1968</b>	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) <b>College Park</b>	21f. LOCATION Street or R.F.D. No. <b>College Park</b>	City or Town <b>College Park</b>	County <b>Montgomery</b>	State			
22a. I certify that (I) (this hospital) attended the deceased from <b>10/04/1968</b> to <b>Nov 6 1968</b> , that (I) (we) last saw the deceased alive on <b>Nov 6 1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE <b>W.C. Etienne</b>	22c. DATE SIGNED <b>11/12/68</b>							
22d. PHYSICIAN'S NAME (Type) <b>W.C. Etienne</b>	22e. ADDRESS <b>College Park</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>Nov 5, 1968</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Mt Olivet Cemetery</b>	23d. LOCATION (City or Town) <b>Washington D. C.</b>	(County) <b>D. C.</b>	(State)			
24. FUNERAL DIRECTOR <b>F. Gasch's Sons</b>	ADDRESS <b>Hyattsville, Md</b>	25a. REC'D BY REGISTRAR DATE <b>NOV 6 1968</b>	25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>					



FOR-STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with the PM3 stamp. Health prior to burial, cremation, or removal, and in any event within 72 hours after death. 5 may be retained for your files.

16458

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

16458

1 DECEASED NAME (Type or Print)			First	Middle	Last	2a DATE KNOWN OF ESTI- DEATH MADE	Month	Day	Year	2b HOUR	
William			R. J.	White		11	6	1968	13:15 am M		
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (In years last birthday)	7 IF UNDER 1 YEAR MONTHS	8 IF UNDER 24 HRS HOURS	9	10	11	12		
Male	White	3-17-1896	72 yrs			DATE PRONOUNCED DEAD	Month	Day	HOUR		
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		9 COUNTY OF DEATH					
New Jersey		USA		WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		Prince George's					
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b KIND OF BUSINESS OR INDUSTRY		
Cheverly			Prince George Hospital			Ret. Heating Eng.					
13a USUAL RESIDENCE (Where deceased lived, if institution, Residence before commision) STATE			13c CITY OR TOWN		13d INSIDE CITY LIMITS?		13e STREET AND NUMBER				
Maryland			Prince George's		Bowie		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			12612 Killian Lane	
14 FATHER'S NAME			First	Middle	Last	15 MOTHER'S MAIDEN NAME	First	Middle	Last		
William					White	Mary			Rahm		
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b SOCIAL SECURITY NO. (If yes give war or dates of service)		17 INFORMANT		130 Village Way Bricktown, N.J.			ADDRESS	
Yes			135-05-5835		Mrs. Mary Allen -						
18b CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)			Heart failure								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH minutes
41			DUE TO, OR AS A CONSEQUENCE OF Arteriosclerotic heart disease								over 5 yrs.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause			(b) DUE TO, OR AS A CONSEQUENCE OF								
(c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
41											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY?
											YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b TIME OF INJURY Month Day, Year HOUR A.M. P.M.		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b)						
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f LOCATION Street or R.F.D. No		City or Town	County	State		
22a I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE			John Kehoe MD								CHIEF MEDICAL EXAMINER <input type="checkbox"/>
EXAMINER'S NAME (Type)			Riverdale, Md.								ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>
											DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>
ADDRESS (Street, city, town, or county)											
23a BURIAL, CREMATION, REMOVAL (Specify)			23b DATE		23c NAME OF CEMETERY OR CREMATORIAL		23d LOCATION (City or Town)			(County)	(State)
Removal-Burial			11/9/68		St. Catherine's Cemetery		Sea Girt			Monmouth	Isle
24 FUNERAL DIRECTOR			ADDRESS				25a REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE	
E. Hopping			Buckley E. Hopping				NOV 7 1968			Charles Judge	
HOPPING FUNERAL HOME - Annapolis, Md.											



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with farm files. 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to a burial, cremation, or removal and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

16453 JU 45-11

1 DECEASED NAME (Type or Print)		First Teruko	Middle Terry	Last Whittaker	20. DATE KNOWN <input type="checkbox"/> Month 11 Day 23 Year 1968 197:25amM OF EST DEATH MATED <input checked="" type="checkbox"/>	2b HOUR 2d HOUR
3 SEX Female	4 RACE White	5 DATE OF BIRTH 9-7-1924	6. AGE (in years last birthday) 44 yrs	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS HOURS MIN	
7a BIRTH-PLACE (State or foreign country) Japan		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Prince George's Md.
10 CITY OR TOWN OF DEATH Cheverly		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Prince George Hospital			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Barber	
13a USUAL RESIDENCE (Where deceased lived, if institution. Residence before military service) Maryland		13c CITY OR TOWN New Carrollton		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER 8510 Caswell Place
14. FATHER'S NAME Faizammon Fukuno		15. MOTHER'S MAIDEN NAME Tsuwa ?				12b KIND OF BUSINESS OR INDUSTRY
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16b. SOCIAL SECURITY NO. —		17. INFORMANT Clarence R. Whittaker (above address)		ADDRESS
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Laceration of brain DUE TO, OR AS A CONSEQUENCE OF Trauma - auto accident Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)						
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH						
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. MEDICAL CERTIFICATION		21b. TIME OF INJURY Month, Day, Year PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH 7:22AM 11-23-1968		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II) fire truck Driver of car involved in collision with		
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) 85th Ave and Annapolis Road, New Carrollton, Prince George Co., Md.		21f. LOCATION Street or R.F.D. No. City or Town County State		
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>						
ACTUAL SIGNATURE <i>John Kehoe</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D.		22b. DATE SIGNED		
EXAMINER'S NAME (Type) John Kehoe MD Riverdale, Md.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		ADDRESS (Street, city, town, or county)		
23a. BURIAL, CREMATION REMOVAL (Specify) Cremation		23b. DATE 11/25/68		23c. NAME OF CEMETERY OR CREMATORIAL Mt. Lincoln Crematory		23d. LOCATION (City or Town) Colman Manor, Md.
24. FUNERAL DIRECTOR Naffey's Funeral Home Inc.		ADDRESS Rainier Maryland		25a. REC'D BY REGISTRAR DA NOV 27 1968		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>



## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

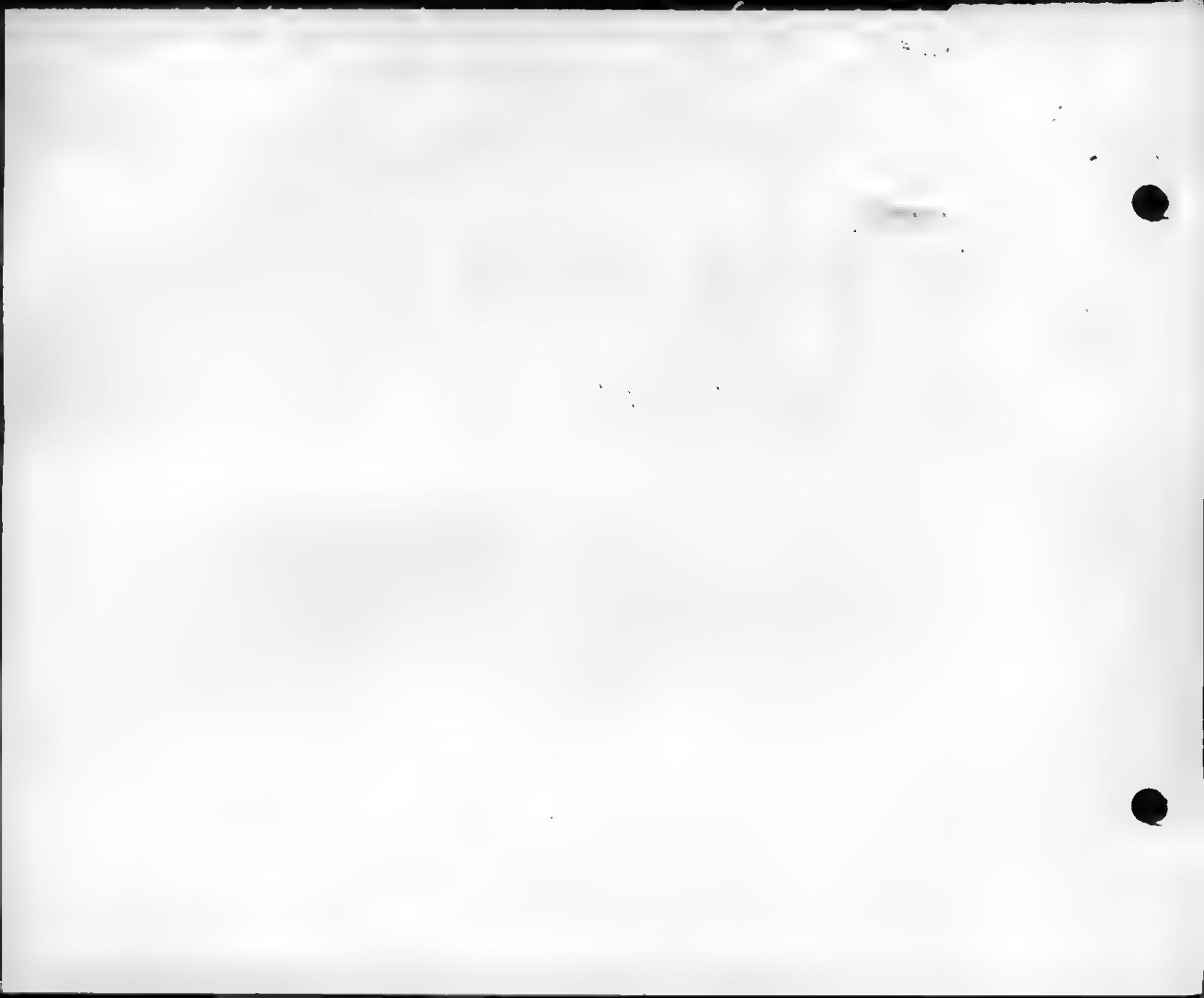
16467

## CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be presented, within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the attending physician, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2, director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2, director, page 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print)	First	Middle	Last	2a. DATE OF DEATH Month	Day	Year	2b. HOUR
GRACE	M	Wilkinson		11	68	230 PM	
3. SEX	4 RACE	S DATE OF BIRTH	6. AGE (In years last birthday) YRS.	IF UNDER 1 YEAR MONTHS	IF UNDER 24 HRS. DAYS	HOURS	MIN.
Female	White	2-13-86	82				
7a BIRTHPLACE (State or foreign country)	7b CITIZEN OF WHAT COUNTRY?	8 MARRIED WIDOWED	NEVER MARRIED DIVORCED	9. COUNTY OF DEATH			
MARYLAND	U.S.A.	<input checked="" type="checkbox"/>	<input type="checkbox"/>	Prince George Md			
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)				12b. KIND OF BUSINESS OR INDUSTRY	
Clinton	Pinelview Garden	House wife				Domestic	
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER			
Md	Pr. George Brandywine	YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	RTI Box 293				
14. FATHER'S NAME	First	Middle	Last	15. MOTHER'S MAIDEN NAME	First	Middle	Last
DAVID	Thomas	Young		ANNA	F	WATSON	
16c. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no (or unknown) (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT	Address				
No	24-36-2849	Harold F Wilkinson	Brandywine				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Sudden vascular collapse</u> <u>1109</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause (b) <u>congestive heart failure</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>myocardial infarction</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>1101</u>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M.	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)				
		19					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or RFD No	City or Town	County	State	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE		22c. DATE SIGNED					
Alfred R Lapin		11-1-68					
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS					
Alfred R Lapin		CLINTON, MD					
23a. BURIAL, CREMATION REMOVAL (check)		23b. DATE	23c. NAME OF CEMETERY OR Crematory		23d. LOCATION (City or Town)	(County)	(State)
Burial Nov 3, 1968			Emmanuel Methodist Cemetery		Bethesda	Md	
24. FUNERAL DIRECTOR		ADDRESS	25a. REC'D BY REG STRR		25b. REGISTRAR'S SIGNATURE		
Hunt Funeral Home, Takoma Park, Md.			NOV 6 1968		Charles Judge		



MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

16455

16464

**10 HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

**10 FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print)			First	Middle	Last	2d DATE OF DEATH Month Day Year	2b HOUR 11/45P M	
ARTHUR LAWRENCE WILLIAMS						Nov 22, 1968		
3. SEX male		4 RACE white	5 DATE OF BIRTH March 14, 1905			6 AGE (In years last birthday) 63 YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	
7a BIRTHPLACE (State or foreign country) Va		7b. CITIZEN OF WHAT COUNTRY? U S A	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH Prince George's Md		
10 CITY OR TOWN OF DEATH Cheverly, Md		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Prince George's Hospital			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Heating Engineer		12b. KIND OF BUSINESS OR INDUSTRY D C Government	
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Md		13b. COUNTY Pro Geo	13c. CITY OR TOWN Lanham			13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	13e. STREET AND NUMBER 7013 Riverdale Road	
14. FATHER'S NAME William H Williams		First	Middle	Last	15. MOTHER'S MAIDEN NAME First Bessie Goodman Middle Last			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown no		16b. SOCIAL SECURITY NO 214 03 0493			17. INFORMANT Lucille M Williams Address Lanham, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) <b>PART I. DEATH WAS CAUSED BY</b> <b>IMMEDIATE CAUSE (a)</b> <i>Concussion of Presto</i> <b>DUE TO, OR AS A CONSEQUENCE OF</b> <b>(b)</b> <i>Metastasis to Pector &amp;</i> <b>DUE TO, OR AS A CONSEQUENCE OF</b> <b>(c)</b> <i>Pector</i> <b>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</b>								
<b>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)</b>								
MEDICAL CERTIFICATION		19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? <input checked="" type="checkbox"/> YES	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)		
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No.	City or Town	County	State
22a. I certify that (I) (This hospital) attended the deceased from <u>11-15</u> , 19 <u>68</u> , to <u>11-22</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>11-22</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE <i>A Deitz</i>		DEGREE	ATTENDING PHYS	<input checked="" type="checkbox"/> MED. DIRECTOR	<input type="checkbox"/> STAFF PHYS.	22c. DATE SIGNED <u>11-23-68</u>		
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS Pro Georges Plaza Hyattsville, Md.						
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE Nov 26, 1968	23c. NAME OF CEMETERY OR CREMATORIUM Ft Lincoln Cemetery			23d. LOCATION (City or Town) Colmar Manor	(County) Pro Geo	(State) Md.
24. FUNERAL DIRECTOR F. Gasch's Sons		ADDRESS Hyattsville, Md.			25a. REC'D BY REGISTRAR NOV 27 1968	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil Item 18. Give Pages 1, 2 and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial/transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

16456

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

16469

1 DECEASED NAME (Type or Print)		First Virgil	Middle Joseph	Last Williams	2a DATE KNOWN OF ESTI- DEATH MATED <input checked="" type="checkbox"/>	Month 11	Day 14	Year 1968	2b HOUR 9:00am
3 SEX Male	4 RACE White	5 DATE OF BIRTH 10-24-1909	6 AGE (in years last birthday) 59	7 MONTHS YRS	8 IF UNDER 1 YEAR <input type="checkbox"/> MONTHS	IF UNDER 24 HRS <input type="checkbox"/> DAYS	MIN. HOURS		2d HOUR 10:00am
7a B.R.T.H.P. (State or foreign country) Virginia		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input checked="" type="checkbox"/>		NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/>	DIVORCED <input type="checkbox"/>	9 COUNTY OF DEATH Prince George's
10 CITY OR TOWN OF DEATH Cheverly		11 NAME OF HOSPITAL OR INSTITUTION (If not a hospital give street address) Prince George Hospital				12a SJAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b KIND OF BUSINESS OR INDUSTRY
13a U.S.A. RESIDENCE (Where deceased lived, if institution address and STATE Maryland)		13c CITY OR TOWN Anne Arundel		13d INSIDE CITY LIMITS? <input type="checkbox"/> YES		13e STREET AND NUMBER Rt. 3			
14 FATHER'S NAME Elbert W.		First Middle Williams	15 MOTHER'S MAIDEN NAME Dora						
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16b SOCIAL SECURITY NO (If yes give war or dates of service) 220-05-6119		17 INFORMANT Mattie F. Williams - same as #13 above		ADDRESS			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Gun shot wound of chest</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost		(b) DUE TO, OR AS A CONSEQUENCE OF		(c) DUE TO, OR AS A CONSEQUENCE OF					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED?				20 AUTOPSY? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
21a EXTERNAL CAUSE WAS PR MARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH		21b TIME OF INJURY Month, Day, Year HOUR AM 9:30am 11-14-68		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b) Shot self at home		21f LOCATION Street or RFD No City or Town County State			
21d INJURY OCCURRED WHITE <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/> home		21e PLACE OF INJURY (At home, farm, street, factory, off ce building, etc.) home		21f LOCATION Street or RFD No same as #13					
22a I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE <i>John Kehoe</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22b DATE SIGNED 11-15-68			
EXAMINER'S NAME (Type) John Kehoe MD b. Riverdale, Md.									
23a BURIAL, CREMATION, REMOVAL (Specify) Burial		23b DATE 11/18/68		23c NAME OF CEMETERY OR CREMATORIAL Hillcrest Cemetery		23d LOCATION (City or Town) Annapolis (County) (State)			
24 FUNERAL DIRECTOR (E. Hopping HOPPING FUNERAL HOME)		ADDRESS Annapolis, Md.		25a REC'D BY REC'D BY NOV 18 1968		25b REGISTRAR'S SIGNATURE <i>John Kehoe</i>			



MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

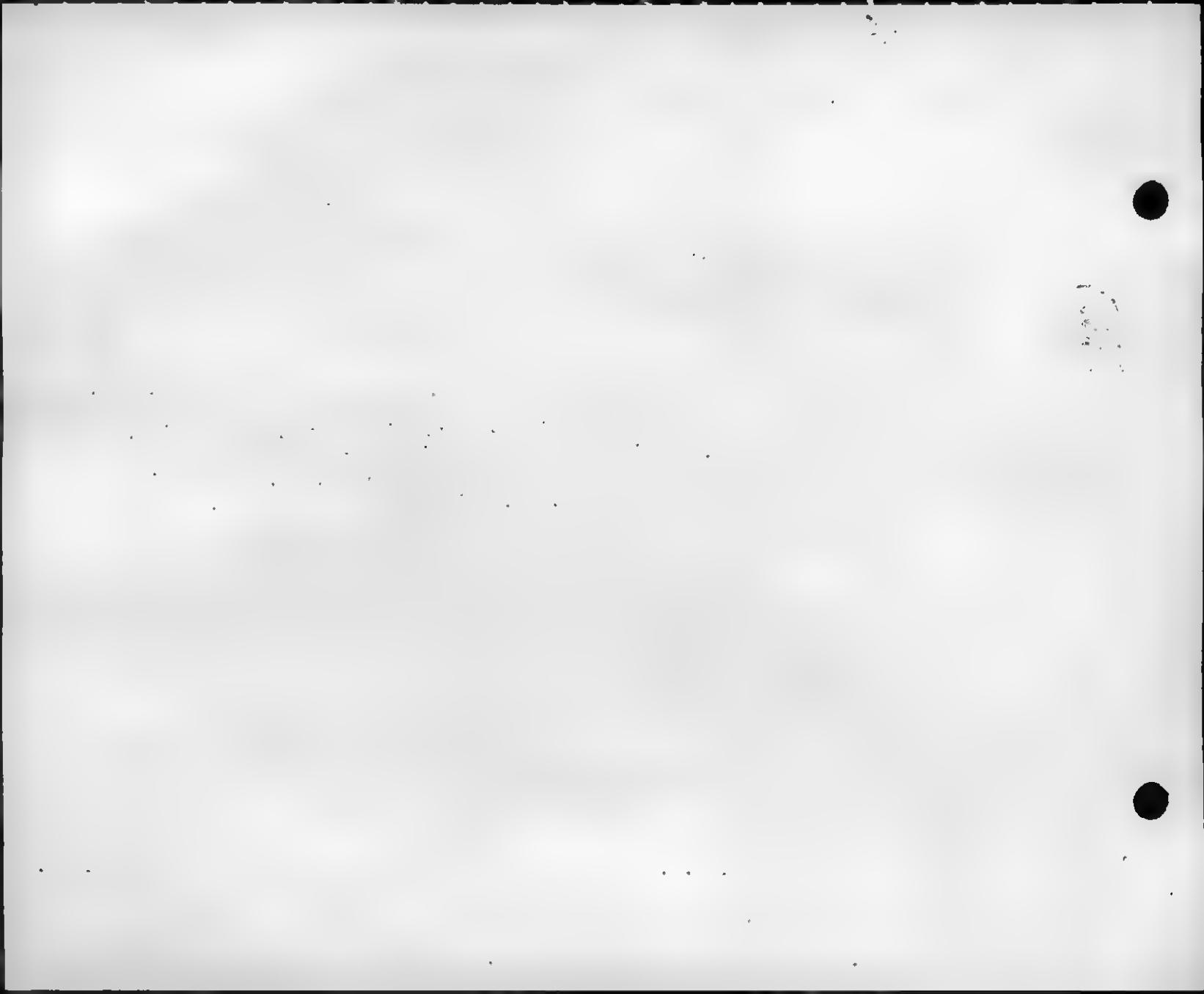
CERTIFICATE OF DEATH

16451

After death  
within 24 hours

**10 HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.  
**Page 4 may be retained by the hospital or attending physician.**  
**10 FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician who completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print)				First	Middle	Last	2a. DATE OF DEATH	2b. HOUR			
				Sydney	T.	Willits	Month Nov. 26, 1968	Day Year	P.M. 10:15		
3. SEX		4 RACE		5. DATE OF BIRTH		6 AGE (In years last birthday)		IF UNDER 1 YEAR			
Male		Caucasian		5/11/06		62 YRS		MONTHS	IF UNDER 24 HRS		
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED		9 COUNTY OF DEATH					
Md		U.S.A.		<input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		Prince George's					
10 CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY		
Cheverly			Prince George's General			Plumber			Construction		
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER			
Maryland			Glenn Dale			YES <input type="checkbox"/> NO <input type="checkbox"/>		Box 204			
14. FATHER'S NAME			First	Middle	Last	15. MOTHER'S MAIDEN NAME			Address		
			David	Willits		Lizzie Fallie			Glenn Dale, Md.		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown)			16b. SOCIAL SECURITY NO.			17. INFORMANT			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
no			577-07-8908			Johanne G. Reynolds					
<p><b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).)</p> <p>PART I DEATH WAS CAUSED BY:</p> <p>IMMEDIATE CAUSE (a) <b>2. Malignant lymphoma involving stomach, and</b> DUE TO, OR AS A CONSEQUENCE OF <b>duodenum and pancreas.</b> 3. Penetrating Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause lost (b) <b>duodenal ulcer.</b> 4. <b>Cirrhosis of the liver.</b> DUE TO, OR AS A CONSEQUENCE OF (c)</p>											
<p>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)</p> <p>02</p>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
						YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County		State	
<p>22a. I certify that (I) (this hospital) attended the deceased from <u>Nov. 2 - 16, 1968</u>, to <u>Nov. 26, 1968</u>, that (I) (we) last saw the deceased alive on <u>Nov. 26, 1968</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.</p>											
22b. SIGNATURE		A Deitz, M.D.				DEGREE	ATTENDING PHYS	<input type="checkbox"/> MED DIRECTOR	<input type="checkbox"/> STAFF PHYS	22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (Type)		Aaron Deitz, M.D.				22e. ADDRESS			11/26/68		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE Nov. 30, 1968		23c. NAME OF CEMETERY OR CREMATORIAL Northeast Cemetery			23d. LOCATION (City or Town) Northeast Cecil		(County) Md		(State)
24. FUNERAL DIRECTOR		ADDRESS				25a. RECD. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
		F. Gasch's Sons Hyattsville, Md.				DEC 2 1968		Charles J. Judge			



## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16458

1647

Item 5 Film G L07 llw 12/6/68

## CERTIFICATE OF DEATH

**10 HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.  
 Page 4 may be retained by the hospital or attending physician.

**10 FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician or attending physician's agent, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print)	First James	Middle A	Last Wilson	Lost	2a. DATE OF DEATH Month 11	2b. HOUR AM 9:55 M	
3. SEX Male	4. RACE Caucasian	S. DATE OF BIRTH 27-9-89	6. AGE (in years last birthday) 80	F UNDER 1 YEAR MONTHS YRS	IF UNDER 24 HRS DAYS HOURS MIN		
7a. BIRTHPLACE (State or foreign country) Delaware	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Prince Georges County	Md			
10. CITY OR TOWN OF DEATH Riverdale	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Elmwood Memorial Hospital	12a. USUAL OCCUPATION (Kind of work done during most of working life even if retired) Retired Clerk	12b. KIND OF BUSINESS OR INDUSTRY Railway Express Co				
13a. USUAL RESIDENCE (Where deceased lived, if institutional Residence before admission) STATE Maryland	13b. COUNTY Prince Georges	13c. CITY OR TOWN College Park	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 4904 Ruatan Street			
14. FATHER'S NAME First ?	Middle	Last	15. MOTHER'S MAIDEN NAME First ?	Middle	Lost		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown? no	16b. SOCIAL SECURITY NO. 577 18 9394A	17. INFORMANT Charlotte Collins	Address College Park, Md.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>HSEVD - Coma</i>						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
4129 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							
DUE TO, OR AS A CONSEQUENCE OF (b) <i>Cerebral</i> DUE TO, OR AS A CONSEQUENCE OF (c)							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(c) <i>Prosthetic hypertrophy</i>							
19a. MEDICAL CERTIFICATION DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING ETC)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State		
22a. I certify that (I) (this hospital) attended the deceased from <i>11/22/68</i> , 1968, to <i>11/23/68</i> , 1968, that (I) (we) last saw the deceased alive on <i>11/23/68</i> , 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) <input type="checkbox"/> view the body after death.						22c. DATE SIGNED <i>11/23/68</i>	
22b. SIGNATURE <i>Verner A. Robertson, M.D.</i>	22d. PHYSICIAN'S NAME (Type) Verner A. Robertson	22e. ADDRESS <i>4404 Queensbury Rd., Riverdale</i>					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE Nov 27, 1968	23c. NAME OF CEMETERY OR CREMATORIAL Gate of Heaven Cemetery	23d. LOCATION (City or Town) Wheaton	(County) Montgomery, Md.	(State)		
24. FUNERAL DIRECTOR F. Gasch's Sons	ADDRESS Hyattsville, Md.	25a. REC'D BY REGISTRAR DEC 2 1968	25b. REGISTRAR'S SIGNATURE <i>J. Charles Judd</i>				



MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16472

CERTIFICATE OF DEATH

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 4 may be retained by the hospital or attending physician.

**Dr. Certificated signed with concurrence of Dr. John Kehoe, Deputy Med Examiner**

16459		16472	
<b>1. PLACE OF DEATH</b> a. COUNTY <b>Prince Georges</b> , MARYLAND		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Oxon Hill</b>		c. LENGTH OF STAY IN lb <b>2 months</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>226 Audrey Lane, Apt. 302</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Oxon Hill</b>	
f. STREET ADDRESS <b>226 Audrey Lane, Apt. 302</b>		g. 5 RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Richard</b> First <b>Moranzell</b> Middle <b>WOOD</b>		4. DATE OF DEATH November 13, 1968	
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Caucasian</b>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>August 11, 1915</b>	
9. AGE (In years lost birthday) <b>53 yrs.</b>		10. KIND OF BUSINESS OR INDUSTRY <b>Building</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Cherrydale, Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S. of Am.</b>	
13. FATHER'S NAME <b>Lilton Wood</b>		14. MOTHER'S MAIDEN NAME <b>Myrtie Walker</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Yes Navy</b>		16. SOCIAL SECURITY NO <b>578-05-9601</b>	
17. INFORMANT <b>Wife</b>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)	
PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <b>4109</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause <b>Arteriosclerotic Hypertensive Heart Disease</b>		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION IN PART I(a) <b>Diabetes Mellitus Known for 7 years.</b>	
19. WAS AN AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ 19 p.m. _____		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that (I) (this hospital) attended the deceased from <b>July 16, 1965</b> to <b>November 13, 1968</b> , that (I) (we) last saw the deceased alive on <b>October 29, 1968</b> , and that death occurred at <b>6:00 P.M.</b> from causes and on the date stated above.			
22a. SIGNATURE <b>Walcutt W. Gibson</b>		22b. DATE SIGNED <b>November 13, 1968</b>	
22c. PHYSICIAN'S NAME (Type) <b>Walcutt W. GIBSON</b>		22d. ADDRESS <b>4300 St. Barnabas Road Marlow Heights, Md. 20031</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>11-13-68</b>	
23c. NAME OF CEMETERY OR CREMATORIAL ESTABLISHMENT <b>Baltimore Natl. Cem.</b>		23d. LOCATION (City or Town) <b>Baltimore</b> (County) <b>Md.</b> (State) <b>Md.</b>	
24. FUNERAL DIRECTOR <b>Wilhelm Funeral Home</b>		ADDRESS <b>133 Suitland Rd. Suitland</b>	
VR A15 (4) 25M 1/67		25a. REC'D BY REGISTRAR <b>No: 60 1968</b>	
25b. REGISTRAR'S SIGNATURE <b>P. Cleaver Judge</b>			



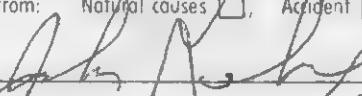
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if necessary, please execute the certificate, writing "and "pending" in pencil in Item 18 give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1647

1. DECEASED-NAME (Type or Print)		First	Middle	Last	2a DATE KNOWN OF ESTI- DEATH MADE <input checked="" type="checkbox"/>	Month	Day	Year	2b HOUR		
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (In years last birthday)	F UNDER 1 YEAR MONTHS	IF UNDER 24 HRS DAYS	HOURS	MIN				
Male	White	10-21-1945	23 YRS								
7a BIRTHPLACE (State or foreign country)		7b CIT ZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH					
Alabama		U S A				Prince George's			Md		
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b KIND OF BUSINESS OR INDUSTRY		
Cheverly		Prince George Hospital				Policeman					
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Maryland		13c CITY OR TOWN Prince George's		13d INSIDE CITY, M TS? Landover		13e STREET AND NUMBER					
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		1954 Brightseat Road					
14 FATHER'S NAME		First	Middle	Last	15 MOTHER'S MAIDEN NAME	First	Middle	Last			
		Edward		Yeszerski	Chella	Culpepper					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b SOCIAL SECURITY NO. (If yes give war or dates of service)		17. INFORMANT		ADDRESS					
		unknown		Veronica K. Yeszerski		1954 Brightseat Rd.					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Multiple gunshot wounds of head and chest</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause (b) DUE TO, OR AS A CONSEQUENCE OF lost. (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?					
						YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
21a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b TIME OF INJURY Month, Day, Year HOUR A.M.		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)							
21d INJURY OCCURRED WHILE AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (At home, farm, street factory, office building, etc.) 7000 Block of Greig Street, Seat Pleasant, Prince George Co., Md.		21f LOCATION Street or R.F.D. No.		City or Town		County		State	
22a I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input checked="" type="checkbox"/> , Undetermined manner <input type="checkbox"/>										CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
ACTUAL SIGNATURE 										MD ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	22b. DATE SIGNED 12-1-68
EXAMINER'S NAME (Type) John Kehoe MD Riverdale, Md.										DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
23a BURIAL, CREMATION, REMOVAL (Specify)		23b DATE Burial 12-4-68		23c NAME OF CEMETERY OR CREMATORIAL Cedar Hill Cemetery		23d LOCATION (City or Town) Suitland		(County) Pr. Geo.		(State) Md.	
24 FUNERAL DIRECTOR Wilhlem Funeral Home		ADDRESS 4308 Suitland Rd. S. E.		25a REC'D BY REGISTRAR DEC 9 1968		25b REGISTRAR'S SIGNATURE 					



Item13 FilmGL07 12/3/68 kk MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16461

CERTIFICATE OF DEATH

16475

**10 HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove from papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 DECEASED NAME (Type or print)	First Floyd	Middle E.	Last Yocum Sr.	2a DATE OF DEATH Month 11 Day 15 Year 68	2b HOUR 815 P.M.
3. SEX Male	4. RACE White	5. DATE OF BIRTH 2/14/1898		6. AGE (In years last birthday) 70 YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN
7a BIRTHPLACE (State or foreign country) Ohio	7b CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	9 COUNTY OF DEATH Pr. Geo.		
10. CITY OR TOWN OF DEATH Lanham	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Magnolia Gardens Nur.	12a USJAL OCCUPATION (Kind of work done during most of working life, even if retired.) Retired	12b KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Maryland	13c CITY OR TOWN College Park	13d INSIDE CITY LIMIT YES <input type="checkbox"/> NO <input type="checkbox"/>	13e STREET AND NUMBER 9259 Limestone Pl.		
14 FATHER'S NAME John E. Yocum	15 MOTHER'S MAIDEN NAME Cora Sabin			Middle	Last
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes/no, or unknown No	16b. SOCIAL SECURITY NO 16c. INFORMANT Mrs. Betty V. Geler - St. Collage	Address 3417-Duke Pk., Md.			
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 hrs					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Pulmonary emboli</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>alveostatic heart disease</i> DUE TO, OR AS A CONSEQUENCE OF (c)					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>Anemia of old age + pulmonary emboli &amp; heart</i>					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No	City or Town	County	State
22a. I certify that (I) (the hospital) attended the deceased from <i>shot</i> , 1967, to <i>Mar 15</i> , 1968, that (I) (we) last saw the deceased alive on <i>11/15/67</i> , 19 <i>68</i> , and that in (my) ( <i>our</i> ) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death					
22b. SIGNATURE <i>John E. Yocum</i>	DEGREE ATTENDING PHYS	<input checked="" type="checkbox"/> MED DIRECTOR	<input type="checkbox"/> STAFF PHYS	22c. DATE SIGNED 11/15/68	
22d. PHYSICIAN'S NAME (Type) <i>Robert Heifsky</i>	22e. ADDRESS <i>3408 Rhode Island &amp; 4th St Rainier</i>				
23a. BURIAL, CREMATION, REMOVAL Burial	23b. DATE 11/19/68	23c. NAME OF CEMETERY OR CREMATORIAL Ft. Lincoln Cem.	23d. LOCATION (City or Town) Colmar Manor, Md.	(County)	(State)
24. FUNERAL DIRECTOR Wallby's Funeral Home Inc.	ADDRESS Mt. Rainier Maryland	25a. REGISTRATION NOV 25 1968	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		



FOR STATE  
HEALTH DEPT.

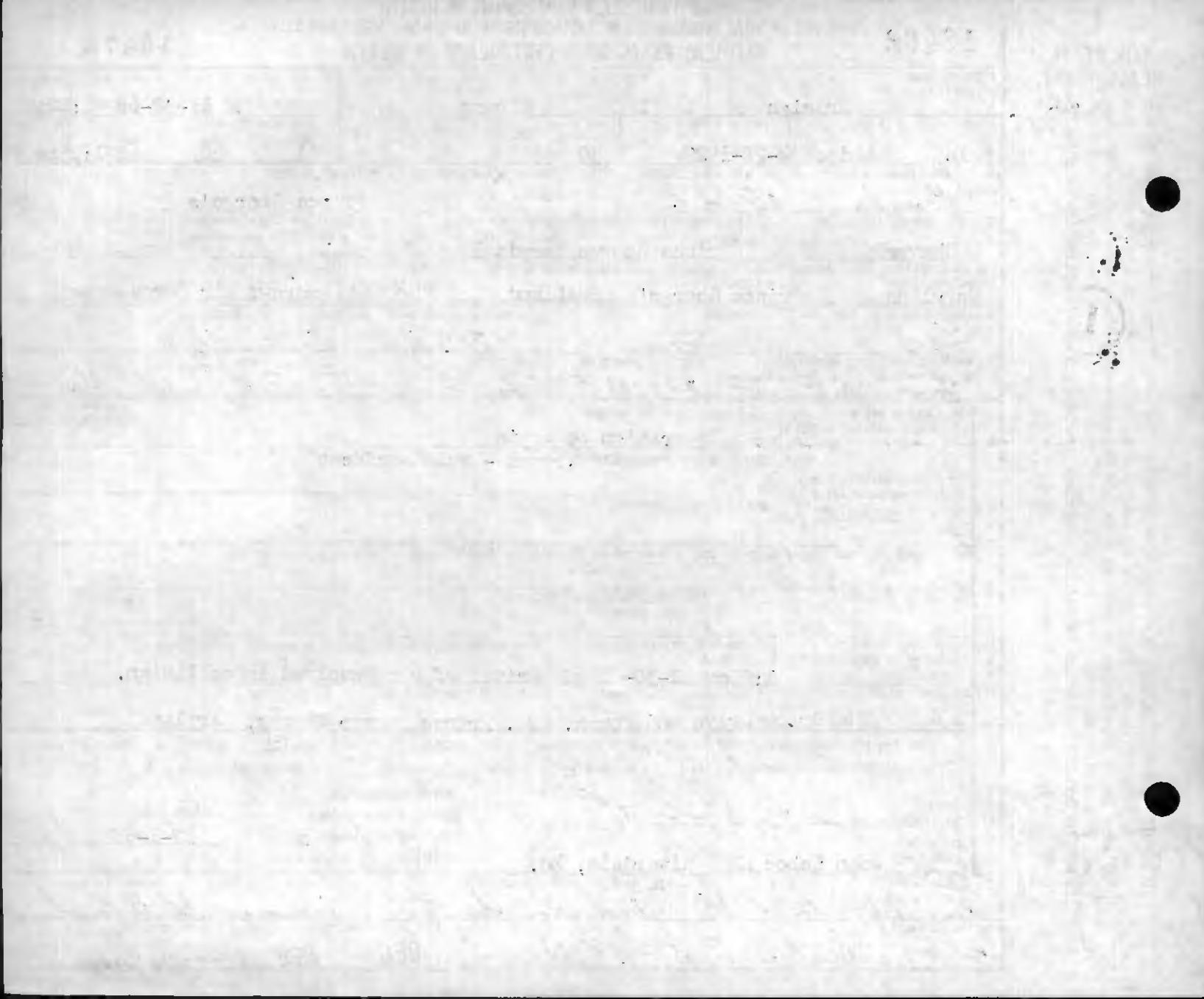
1  
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with farm PM3. Page 5 may be retained for your files.  
2  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

16476

1. DECEASED NAME (Type or Print)		First	Middle	Last	2a. DATE KNOWN OF ESTI- DEATH MATED	Month	Day	Year	2b. HOUR	
		Arleigh	L	Young	<input checked="" type="checkbox"/> 11-30-68	19	1	02am	M	
3. SEX	4. RACE	S. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS HOURS MIN	2c. DATE PRONONCED DEAD Month Day Year				2d. HOUR
Male	White	2-28-1929	39 YRS.			11	30	68	1:15am	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		9. COUNTY OF DEATH		Prince George's		
Georgia		El. d. a.		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				Md.		
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)				12b. KIND OF BUSINESS OR INDUSTRY
Cheverly		Prince George Hospital				Non-Com. officer				U.S.A.F.
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER		
Maryland		Prince George's		Suitland		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		Andrews Air Force Base		
14. FATHER'S NAME		First	Middle	Last	15. MOTHER'S MAIDEN NAME		First	Middle	Last	
Lee				Young	Mehow Connally					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
No		254-38-5515		Lee Young R.F. 1		Fitzgerald Ga.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										
PART I. DEATH WAS CAUSED BY:										
IMMEDIATE CAUSE (a) Laceration of brain										
DUE TO, OR AS A CONSEQUENCE OF Trauma - auto accident										
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)										
DUE TO, OR AS A CONSEQUENCE OF										
(c)										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
8164										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?				
						<input type="checkbox"/> NO <input checked="" type="checkbox"/>				
MEDICAL CERTIFICATION		21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M.		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)		21f. LOCATION Street or R.F.D. No. City or Town County State		
		WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		1:00am 11-30- 19 68		Driver of car involved in collision.				
21d. INJURY OCCURRED		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State						
		Brook Drive and Penna. Ave. Prince George County, Maryland								
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>										
ACTUAL SIGNATURE		John Kehoe MD Riverdale, Md.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22b. DATE SIGNED		
EXAMINER'S NAME (Type)						M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		12-1-68		
23a. CERIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS		23d. LOCATION (City or Town) (County) (State)		25a. REC'D BY REGISTRAR		
Burial		12-5-68		Anderson Cemetery		Anderson South Carolina		DATE DEC 5 1968		
24. FUNERAL DIRECTOR						25b. REGISTRAR'S SIGNATURE				
W. W. Chamber Co. 517-11 E. St. S.E.										



FOR STATE  
HEALTH DEPT.

any delay is  
r death  
ive Page 1, 2, and 3 to  
with form  
the Lat. Department of

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give the funeral director Page 4 should be forwarded to the Chief Medical Examiner's Office along 5 may be retained for your files.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with Health prior to burial, cremation, or removal and in any event within 72 hours after death.

**MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201**  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

1. DECEASED-NAME (Type or Print)			Firs!	Middle	Last	2a. DATE KNOWN OF ESTI- DEATH MATED	Month	Day	Year	2b. HOUR	
Jeffrey T Zoller						<input checked="" type="checkbox"/>	11	4	68	19 12:45am	
3. SEX	4. RACE	S. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS						
Male	White	8-13-1947	21 YRS	MONTHS	DAYS	HOURS	MIN.				
7a. BIRTHPLACE (State or foreign country) New York		7b. CITIZEN OF WHAT COUNTRY? U S A		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Prince George's			2d. HOUR		
10. CITY OR TOWN OF DEATH Cheverly			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Prince George Hospital			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Student			12b. KIND OF BUSINESS OR INDUSTRY College		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) Michigan			13c. CITY OR TOWN Oakland			13d. INSIDE CITY LIMITS? Farmington			13e. STREET AND NUMBER YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> 24690 Madison Court		
14. FATHER'S NAME Marshall I Zoller			15. MOTHER'S MAIDEN NAME Imogene P Patterson								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no			16b. SOCIAL SECURITY NO. (If yes give war or dates of service)			17. INFORMANT Marshall Zoller			ADDRESS		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Laceration of brain stem Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 8120									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 8 days		
(b) Trauma - auto accident DUE TO, OR AS A CONSEQUENCE OF Fractures of cervical vertebrae (c) DUE TO, OR AS A CONSEQUENCE OF											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 8164											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY?					
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year HOUR A.M. 1:15am 10-27-1968			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) Driver of car involved in collision			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) Baltimore Washington Parkway, Cheverly, Prince George Co., Md.			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <i>J. Kehoe MD</i>											
EXAMINER'S NAME (Type)			M.D.			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22b. DATE SIGNED 11-4-68		
John Kehoe MD			Riverdale, Md.			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					
EXAMINER'S NAME (Type)						DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
						ADDRESS (Street, city, town, or county)					
23a. BURIAL, CREMATION REMOVAL (Specify) Cremation			23b. DATE Nov 5, 1968			23c. NAME OF CEMETERY OR CREMATORIAL Ft Lincoln Crematory			23d. LOCATION (City or Town) Colmar Manor Pro Geo		
24. FUNERAL DIRECTOR			ADDRESS F. Gasch's Sons Hyattsville, Md.			25a. REC'D BY REGISTRAR DATE NOV 7 1968			25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		

100.00

100.00 100.00 100.00 100.00 100.00

100.00 100.00 100.00 100.00 100.00

100.00 100.00 100.00 100.00 100.00